

# The Abnormal Person and His World

**PAUL J. STERN**



**THE  
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The Abnormal Person  
and His World

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# THE ABNORMAL PERSON AND HIS WORLD

*An Introduction to Psychopathology*

by PAUL J. STERN  
*Harvard University*



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## Preface

This book is intended as a text for college students and students at professional schools. It grew out of a course in abnormal psychology which the author has offered for a number of years at the Harvard Divinity School.

As is often the case in graduate schools, the author's original audience consisted of students with widely varying academic backgrounds. Some had majored in psychology, others were innocent of any formal acquaintance with psychological concepts. The author responded to this pedagogical challenge by shifting back and forth, in his lectures, between various levels of psychological sophistication. This manner of presentation has been partly preserved in the present book. It is reflected in the style of printing in that some of the more complex material has been indented. This material is meant to enrich the reader's basic fare; it is not intended to give him indigestion.

A word on the choice of subject matter. This book is selective. Some theoretical issues and clinical areas are given considerable play, at the expense of others. Thus the author has omitted to deal with organic psychoses, epilepsy, and mental deficiency—areas which, in his judgment, are only of tangential interest to most non-clinicians. With regard to theory, psychoanalysis and existential analysis have been given preferential treatment, which reflects less the author's belief in the perfection—or even the perfectibility—of these two approaches, but rather his discontent with the relative paucity of competing others.

Paucity is the word which the author would use, in particular, to characterize much of the voluminous, and inexorably growing, body of laboratory work which prides itself on a stringent use of the experimental method. In the field which interests us, this experimental approach has been embodied most forcefully in the work of Eysenck and his collaborators. If the author has chosen to make scant reference to this work, it is because he cannot bring himself to consider its present yield as more than remotely relevant to clinical concerns. This skepticism may be due to a personal quirk of temperament, but if so,

it is one shared with many clinical colleagues. Like them, the author registers a consistent failure of most laboratory studies to come to grips with the essential richness and complexity of clinical phenomena. Perhaps the method is inadequate; perhaps it stands in need of refinement. The issue need not be prejudged at this point. But until it brings forth more nourishing, substantial fruit the author begs to be allowed, by his experimentally inclined colleagues, to rely mainly on the traditional methods of clinical observation.

Clinical observation does not necessarily mean psychoanalysis. In fact, the author favors a descriptive approach which nowadays goes by the labels of "phenomenological" and "existential" psychology and which in important respects is at odds with Freudian analysis. The latter seems to be one-sidedly preoccupied with the hidden depths, the invisible psychic dynamisms and unconscious processes postulated to exist "underneath" the "surface" of immediate psychological experience. The themes to be discovered in these depths—such as the Oedipal theme—have turned out to be stereotyped and strictly limited in number; perhaps, then, the time is ripe for a return to the "surface." The "return to the phenomena themselves," advocated most articulately in psychology by the Frenchman Merleau-Ponty, may turn out to be the needed antidote against the formalistic scholasticism whose deadening weight is visible in so many psychoanalytic and psychoanalytically inspired publications.

Such questions of psychological method nowadays reach beyond the confines of purely technical discussion among professionals. An increasing number of students conceive of courses in abnormal psychology not primarily as offering access to just another body of scientific knowledge or as a means to narrowly utilitarian ends, but rather as being part of a humanistic endeavor which holds out the promise of enhanced self-knowledge. Ever since Freudian psychology rediscovered the continuity of the normal and abnormal, psychopathology has been transformed, in the mind of the educated layman, from a collection of fascinating, but largely irrelevant, psychological curiosities into a discipline of direct relevance to the understanding of the human condition. This trend has accelerated in the last fifteen years or so, which have witnessed also an increasing clinical interest in the study of psychotic, and especially schizophrenic, conditions. Under the impetus of Binswanger, Jaspers, Boss, and similarly minded, "existentialist" investigators, we have come to think of the alienated schizophrenic as the unwitting explorer and herald of unfathomed boundary areas of human life, whose uncanny experiences reveal ex-

treme possibilities of forlornness which usually remain in the shadow, but which nevertheless, invisibly present, define the structure of every human existence. Thus, while many a student will not find in abnormal psychology the concrete answers to pressing personal problems he looked for, he may extract something of more general humanistic value from its study.

\* \* \* \* \*

Obviously, the author of a book like the present one contracts, during the period of gestation and production, a large total of private debts which may be acknowledged, but cannot be paid, in public. My deepest indebtedness, in this connection, is to my wife, who has borne with smiling graciousness and tolerant understanding the difficult lot of being a preoccupied author's spouse.

Intellectually, I am much indebted to Professors David C. McClelland and Gordon W. Allport who, acting as publisher-appointed and self-appointed readers, respectively, have made their presence felt in a most constructive way. A many-faceted debt which, I am afraid, is beyond repayment is owed to Dr. Charles C. McArthur, who with unstinting generosity assumed the multiple roles of clinical advisor, intellectual conscience, literary critic, and proofreader. I found him always equally ready to discuss the most recondite point of existential-analytic doctrine or the placement of a simple comma. He allowed me, in the most liberal manner, to draw upon his richly furnished, sharply analytical mind, without expecting any other return than an improved manuscript.

In the final stages of revision, help came from a rather unexpected quarter, namely, from an anonymous reader appointed by the publisher whose twenty-five single-spaced pages of lucid comment turned out to be most valuable. And finally, when secretarial help was badly needed, it was found in the person of Mrs. Joan Erdman who, with devoted conscientiousness, helped to see the manuscript through its last, critical stages.

*Lexington, Massachusetts*  
*June 1964*

PAUL J. STERN

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# I

## Abnormality and Its Social Setting

### *The Concept of Abnormality*

In a quite literal sense, "abnormality" and "disease" are negative concepts. "Abnormality" means deviation from a norm or standard, whereas "disease" signifies a lack of vital ease. This means that the negative concept (abnormality, disease) presupposes the positive one (normality, health), and can only be explained in terms of it. The deviant is defined by what it deviates from. If abnormality is the negation of health, it will be defined by means of the inverted attributes of health. Thus if one describes (as is often done) normality in terms of harmony or balance, pathology will be characterized by dissonance and lack of equilibrium.<sup>1</sup>

Some behavioral scientists (Szasz, 1960; Mowrer, 1961) would like to banish such terms as "illness" and "pathology" from the field of abnormal psychology. One of their objections is that these words are burdened with all sorts of theoretical presuppositions and connotations originating in somatic medicine—presuppositions which may be misleading or irrelevant if applied to the field of emotional disorders. Thus the word "illness" is apt to conjure up in the mind of the medical man the notion of a "disease entity" and of an "underlying disease process," preferably of a somatic nature. The author should like to make it clear

<sup>1</sup> Strictly speaking, the common practice of using "abnormal" and "pathological" as synonyms is not correct. There is a difference in meaning. "Pathology" refers to *harmful* or *undesirable* departures from the norm, whereas *all* deviations from the norm, including nonpathological ones, are properly called "abnormal." A person may be abnormally tall, without his tallness being pathological. However, current usage tends to ignore these distinctions.

that in talking of "emotional illness" he does not espouse this somatic prejudice nor any special theory about the nature and the causes of mental disease. (Nor does such usage imply that a person suffering from an emotional disorder need, of necessity, be treated by a man with an M.D. degree.) Why then, the reader may ask, talk of emotional illness at all? Why not confine ourselves to such concepts as emotional disorder? The reason is twofold: (1) Illness implies, in our culture, that the person afflicted is seen as being in the grip of a "condition" to which moral categories, for example, sin and punishment, are not directly relevant. (2) Illness also implies a well-defined set of social attitudes crystallized in the social institution of the "sick role" with its obligations (to get well) and privileges (being cared for). Both (1) and (2) are directly relevant to the contemporary understanding of emotional disorder.

There are two ways of establishing a standard of normality. One is the *statistical* way which defines normality in terms of what is usual or average. The other one is the *normative* approach which tries to set up some qualitative norm, such as adjustment or integration. Such a norm is not arrived at by statistical computation, but is *constructed* on the basis of empirical observations. Far from reflecting an arithmetic average, it may actually embody an ideal type, an extreme (asymptotic) value which need not be fully realized in any single case. The ideal type of the "fully integrated" person is not to be found in everyday reality.

The statistical approach to normality is particularly appealing to the modern medical and behavioral scientist because, apparently, it involves a minimum of arbitrary value options. To establish whether a certain trait is usual or average seems to require only counting and simple arithmetic. It is easy to establish the normal range of temperature or blood acidity of the human body. Once having done so, it is simple to agree that a body temperature of 102 degrees Fahrenheit is abnormal. (It is less easy to decide where exactly to draw the borderline between normal temperature and fever, but this decision is usually of minor practical import.) Matters are much more complicated if we try to set up a statistical average of *health*. Health is a composite notion which cannot be defined in terms of any single physical variable, such as body temperature or blood acidity. But it could conceivably be gauged in terms of a number of fairly straightforward indices of which body temperature and blood acidity might be two.



However, even if we could establish a statistical average of health, we still would be hard put to define *pathology* in statistical terms. Two of the more obvious obstacles to such an undertaking are as follows: (1) There are statistical abnormalities, such as unusual physical strength and extreme longevity which, far from indicating sickness, denote an excess of health. Statistics by itself would be hard put to decide which abnormalities are healthy and which ones pathological. (2) Inversely, there are conditions, such as dental caries or the common cold, which in spite of their being extremely frequent (normal or quasi-normal) are nevertheless clearly pathological. Again, criteria external to statistics have to come into play to distinguish such pathological normalities from those to be taken at face value. For these and other reasons, it is clear that the seemingly plausible attempt to define abnormality in purely quantitative, "value-free" terms is doomed to fail.

It is noteworthy, however, that on the level of physiology, as reflected in such variables as plasma acidity or blood cell count, the statistical average frequently corresponds to the optimum. Already one of the first statisticians, the Belgian astronomer Quetelet, was much impressed by the coincidence between biological norm and statistical normality. His observations along this line led him to postulate that the average man corresponds to the ideal man created in keeping with the canons of God. For Quetelet, the average and the ideal norm were identical.

Quetelet's argument was divested of its theological ideology and reformulated by Canguilhem (1943), who reasoned that what is most frequently encountered represents the optimum to be attained under a given set of circumstances, that is, an equilibrium. Thus for Canguilhem the average is no longer identical with an absolute ideal norm, as it was for Quetelet, but it expresses a limited ideality (a quality or state of being ideal) relative to a given framework. This ingenious attempt to "relativize" the ideal norm, and thus to bring it within the realm of statistics, may be valuable on the biological level. But it fails us on the level of social and psychological phenomena as is shown by the rather obvious fact that the optimally adjusted members of a given group or class are always a minority rather than a majority. It appears that the association between statistical norm and ideal norm is much closer in biology than in psychology and social psychology, and perhaps closest at the level of lower organisms.

The example of dental caries, which is statistically normal and yet pathological, makes it abundantly clear that our judgments about health and disease are always guided by qualitative norms, whether implicit or explicit. Undoubtedly, such qualitative norms—for example, those of integration and homeostatic balance—are not constructed out of thin air, but reflect in their turn empirical observations. Hence our concepts of health and disease really constitute a confluence, a fusion, hard to disentangle, of statistical and normative elements.

Given the difficulties of the attempt to define the concepts of health and pathology, one may well wonder if such an endeavor is worthwhile. In fact, in somatic medicine where it is usually quite clear whether or not one is in the presence of organic malfunction or impairment, little time is spent on such philosophical ventures. The internist and the surgeon usually recognize disease when they see it even though they may be unable to define the concept of disease in a satisfactory manner.

Psychologists and psychiatrists, on the other hand, seem unable to do without such a definition. This is not because of any innate or acquired predilection, on their part, for recondite verbal games, but rather because in their field the distinction between normal and abnormal is both difficult and of daily practical relevance. Thus, if faced with a student who finds himself unable to study, the psychologist must know whether to attribute the student's academic failure to some unconscious conflict which qualifies as illness, or whether to a "lack of moral fiber" or a lack of conscious motivation which is not considered as incompatible with health. In the first case, the student may be nursed along with psychotherapy or granted a medical leave; in the second case, he may be booted out of school without much ceremony. Unfortunately, this diagnostic decision on which a career may hinge is sometimes very difficult to make.

#### THE SHIFTING BORDERLINE BETWEEN HEALTH AND DISEASE

Those who want conclusive evidence of the uncertainty of the borderline between mental health and pathology need only glance through a history of medical psychology or a book on social psychiatry. They will find that this borderline has shifted time and again, from historical era to historical era. (The Middle Ages interpreted as demonic possession what we now call a mental illness, and, until fairly recently, this concept of illness was applied in the psychic realm only to the most extreme forms of disorder, what was called

idiocy, lunacy, and deep melancholy.) In the same historical era, this borderline is drawn differently in different societies, or in the different social strata of the same society. A piece of dishonesty, indulgently glossed over as "neurotic" by a middle-class psychiatrist if perpetrated by a member of his own class, may be labeled "psychopathic" or "criminal" if pulled off by a slum dweller. A certain type of beatnik or other eccentric may appear more or less sick, depending on whether one judges him from the vantage point of upper- or middle-class values. Clinical criteria of mental health and disease are rarely clear-cut enough to be independent of social values. They are influenced by the group's or the individual's moral ideology, by the state of scientific knowledge, and by the perfection of therapeutic methods. They are subject to sudden shifts brought about by ideological or scientific revolutions.

Thus one observes in this country and in other Western societies that in the few decades since the advent of psychoanalysis the sphere of emotional illness—or of what is interpreted as such—has remarkably expanded, and the domain of health correspondingly shrunk. And since, to the Western way of thinking, a condition diagnosed as "illness" limits the afflicted person's moral liability, the proliferation of disease entails also a contraction of the domain of personal freedom and responsibility. Disease "infantilizes": it entitles to exemptions from the daily round of duties and to various allowances. We do not berate a student for laziness if we attribute his delay in finishing a term paper to a neurotic study block. Most present-day psychologists think of those forms of maladjustment which we call neuroses as of genuine forms of psychic disease which are as little subject to moral suasion and the appeal to conscience as a broken leg. In fact, as Kaplan (1957) has pointed out, one can conceive as the aim of psychotherapy to bring about a condition in the patient, to which moral categories are at last fully relevant. However, it is perfectly conceivable that 20 years from now moral muscle-building and spiritual exercises will become once more fashionable for dealing with certain types of neurotics who then will no longer pass for "sick." Mowrer's (1961) attempts to reclaim the categories of sin and expiation for abnormal psychology may well be symptomatic of such a development.

By now it ought to be clear that to find criteria which distinguish between mental health and pathology is both a perplexing and important task. Still less than in somatic medicine, can we hope to establish normality in statistical terms. Even if such an endeavor were theoretically feasible, we would be fatally handicapped by the fact,



stressed by Redlich (1957), that "we know nothing of the distribution in the total population of those behavior variables in which psychiatrists are particularly interested, such as anxiety, depression, hallucinations (omitting entirely the more inferentially derived processes of identification, repression, projection, etc.)" (p. 141). We just do not know how anxious or dejected the average man is. And to the extent that we think we know we are likely to be mistaken. Psychiatrists who deal with unselected control subjects are struck time and again by how much "pathological" material they discover in these supposedly normal populations. The statistical approach to the identification of mental pathology being so patently impractical, the psychological clinician has to rely heavily on qualitative criteria. Let us examine, then, these criteria in some detail.

#### "INTEGRATION"—A QUALITATIVE CRITERION OF MENTAL HEALTH

One of the most basic attributes of the living organism is integration, the hierarchical ordering and functional interdependence of its structural elements (organs). Integration implies that what affects one organ also affects others. Strictly speaking, the organism knows few if any purely local events.

The concept of integration has been widely used by neurologists whose main object of study, the nervous system, is the integrative structure of the organism *par excellence*. The whole nervous system is organized in a strict hierarchical order, the higher centers controlling and modulating, by partial inhibition, the lower ones.

In neuropathology, we observe a partial collapse of this hierarchical structure. An impairment of the higher functions leads to release phenomena (disinhibition) at the lower level. The condition where subsystems of the organism gain local autonomy is called *disintegration*.

In psychopathology, this notion of disintegration has proved equally serviceable. Most psychologists conceive of the structure of the personality as an organized whole composed of subsystems. These subsystems are controlled by the integrative action of the "I" (ego) or self. Under stress, this hierarchical structure tends to break down; the subsystems emancipate themselves from the central authority. We are in the presence of a divided or dissociated personality; in the (rare) extreme case, of multiple personalities. Much of psychopathology can be analyzed, if one is so inclined, in these terms.

Among the theorists of personality, Kurt Goldstein (1939) in particular has formulated mental pathology in terms of a failure

of integration. Using his studies of brain lesions as his point of departure and drawing upon the theories of Gestalt psychology, Goldstein sees the total organism as a form (Gestalt) which has a structure and finality of its own. Mental pathology means the perversion or absence of this organismic finality. It involves a loss of function leading to "disordered behavior," which results in "catastrophic reactions," and is reflected on the subjective level by anxiety. This anxiety is interpreted as an expression of impotence, of incapacity to meet the demands of the environment and to actualize the inherent potential of the organism. This does not mean that disease is a mere deficiency phenomenon to be described in purely negative terms (impairment of certain functions). The sick organism strives to realize a new organization or pattern of its own. Disease, according to Goldstein, always entails this attempt at reintegration, more or less successful, and at a lower level of functioning, to be sure—but reintegration, nevertheless. Partial recovery, then, means "a newly achieved state of ordered functioning, i.e., responsiveness, hinging upon a specifically formed relation between preserved and impaired performances. This new relation operates in the direction of a new individual norm, of new constancy and adequacy" (Goldstein, 1939, p. 439).

The concept of integration, while useful in guiding our thinking about mental health, has the drawback of overgenerality. Not being anchored very closely to exactly specifiable variables, it is apt to leave us in the lurch in the concrete case if we want to make more than the most general statements. The same strictures apply to other frequently used qualitative criteria, such as those of homeostatic balance or adaptation.

#### CLINICAL CRITERIA OF HEALTH AND PATHOLOGY

A seemingly more straightforward criterion of abnormality is proposed by the so-called clinical approach which defines health and disease in terms of absence or presence of symptoms. Symptoms are manifestations of dysfunction which lead to complaints on the part of the affected person (pain, fever, loss of appetite). As long as the patient is free from symptoms, he considers himself as healthy, and so does his doctor—and they are usually, though not always, justified in doing so. (There are diseases, such as early stages of stomach cancer, which are asymptomatic.) This clinical approach for which normality means the absence of disease is basically a modest one. It

defines health in terms of minimal rather than maximal performance. "In the treatment and diagnosis of a patient with muscular weakness in his legs, the physician will be concerned with the patient's ability to walk, not with his ability to establish a new sprint record" (Redlich, 1957, p. 143).

The clinical criterion of the presence or absence of symptoms works quite well in the field of somatic medicine, but it is more complex than it looks at first glance when applied to abnormal psychology. Symptom means "sign or index of pathology"; it means that an event or appearance is empirically correlated with the existence of pathology, and hence presupposes a notion of what is pathological. If a person suffers from recurrent nightmares we are usually quick to concede that he is exhibiting a valid symptom of emotional upset; similarly, this is true if somebody experiences hallucinations in which he accepts sense imaginations as real. (But there are reports of hallucinations occurring in normal people.) But how about a person who displays to some excess a usually positively valued character trait? Do we conceive of great ambition or extreme scrupulosity as achievements or as (neurotic) symptoms? Or at what point do they cease to be the one and become the other? A person may be free from psychological symptoms in the usual sense—free from unusual anxiety, guilt, sadness, haunting irrational thoughts—and may yet be adjudged to be sick. Abnormal psychology talks of symptom-free or asymptomatic neuroses in which the pathology consists in the distortion of a whole character structure or style of life ("character neuroses"). Obviously, the clinical approach, as much as the statistical and normative one, has its difficulties when applied to the realm of psychopathology.

#### PSYCHOANALYTIC CRITERIA OF PATHOLOGY

Categorical judgments about mental health and disease were so much easier in the days of pre-Freudian psychology when only the more extreme forms of psychological deviations were qualified as "sick." No single person has done more than Freud to topple the once rigid border wall between the normal and the abnormal. By dwelling on the symptomatic aspects of dreams, errors, and other indices of the "psychopathology of everyday life," and by pointing out their similarity to neurotic symptoms, Freud established the continuity between normal and abnormal psychic life. He was particularly impressed by how closely the dreams of normal people resemble those of neurotics:

The dreams of neurotics, however, differ in no essential from those of normal people; they are indeed perhaps not in any way distinguishable from them. It would be illogical to account for the dreams of neurotics in a way that would not also hold good of the dreams of normal people. We have to conclude therefore that the difference between neurosis and health prevails only by day; it is not sustained in dream-life. It thus becomes necessary to transfer to healthy persons a number of conclusions arrived at as a result of the connections between the dreams and the symptoms of neurotics. We have to recognize that the healthy man as well possesses those factors in mental life which alone can bring about the formation of a dream or of a symptom. . . . The healthy man too is therefore virtually a neurotic, but the only symptom that he *seems* capable of developing is a dream. To be sure when you subject his waking life also to a critical investigation you discover something that contradicts this specious conclusion; for this apparently healthy life is pervaded by innumerable trivial and practically unimportant symptom-formations (Freud, 1953, p. 464-465).

But even though it narrowed the gap between health and disease, psychoanalysis did not deny the practical and theoretical importance of this distinction. Freud and his students have attempted to redefine normal and abnormal within the framework of psychoanalytic theory. Two of the more important criteria advanced by them are the following:

1. *Consciousness of motivation* Among psychoanalytic authors, Kubie (1950, 1954, 1957), in particular, has emphasized consciousness of motivation as a touchstone of mental health. Since psychoanalysis equates consciousness with rationality, the following formula applies: The more consciousness, the more rational direction, the more health; the more unconsciousness, the more blind giddiness, the more pathology. What are some of the characteristics by which we recognize unconsciously motivated behavior? They are rigidity, stereotyped repetitiveness, and insatiability. Action patterns which are largely dominated by unconscious purposes "are not modifiable by conscious experiences of pleasure or pain, success or failure, reward or punishment, argument or exhortation" (Kubie, 1957, p. 82). They lack the flexible plasticity of normal behavior which is modified by experience and learning. What appears superficially as the same behavioral act may be normal or neurotic depending on what the constellation of motivating forces is. Kubie gives the example of a child eating. The healthy child eats to satisfy his hunger and then goes on to something else. A neurotic child whose neurosis centers around food may eat until he vomits and then start all over again. At the subjective level, it is the element of feeling unfree, of feeling forced to give in to an overpowering, insati-



able impulse—often experienced as alien—which is the most characteristic feature of unconsciously motivated behavior.<sup>2</sup>

It is at this (psychological, not metaphysical) level that the element of "freedom" enters into psychoanalysis. To be free, for the analyst, means to be free from the feeling of internal compulsion, and its attendant affect, anxiety (which arises if the compulsion is resisted). It means subjectively that one experiences oneself as making deliberate choices between alternatives, and descriptively that these choices are made by the conscious part of the personality (the ego)—or, at least, filtered through it. This *feeling* of freedom is recognized by Freud as a psychological reality, but such recognition does not imply the acknowledgment of the causal efficacy of a spontaneous "free will," which is expressly denied by the Freudian doctrine of determinism.

Unconsciousness of motivation is undoubtedly a useful criterion of pathology, but it is not an unerring one. It reflects a peculiar bias of the Freudian orientation, that is, the tendency to overestimate the positive value of rationality and consciousness, or rather to underestimate the creative potential of the unconscious (C. G. Jung). There are moments of artistic inspiration or of religious ecstasy in which consciousness seems to sink away, and the sphere of the unconscious to take over—moments which may bear such rich harvest of objectified beauty or insight that it would seem absurd to call them pathological.

2. *Psychosexual maturity* One of the major contributions of Freud was the establishment of an approximate timetable of early psychobiological ("psychosexual") development, which allows one to gauge the person's relative maturity. It is the merit of such a schema to bring out the importance of the developmental dimension of man for psychopathology.

The genetic approach upon which this schema is based envisages man as having to run a predetermined universal obstacle course, the critical points of which require him to renounce habitual and pleasurable modes of action in favor of unfamiliar, more mature, ones. This transition to the new phase is often not easily made, for at its

<sup>2</sup>To be more precise, we should talk of behavior which is *largely* or predominantly motivated by unconscious forces. No act is completely motivated by unconscious factors, as none is entirely uninfluenced by them. It is always a matter of more or less, of the relative preponderance of conscious or unconscious processes in the balance of motivation.

threshold lurks the dark specter of anxiety. If the anxiety is more than the individual can bear, he will refuse the challenge and cling to the security of the outlived past. The price he pays for this evasion is the loss of psychic, and sometimes also physical, health.

If one uses this genetic approach, the maturity of the personality is measured against an ideal schema of development; if it is found to lag, the person is adjudged to be sick. Should there be a lag, it may mean that the organism got stuck at a certain stage of development (fixation) or that, having gotten stuck, it had then to fall back upon earlier, more archaic, positions which had been abandoned (regression).

Psychoanalysis envisages the crucial life tasks which man encounters in his development as psychobiological ones in which the instinctual energy (libido) progressively invests different bodily zones (mouth, anus, genitals) and makes them the center of "sexual" interest, the main purveyors of pleasure. These crucial transitions take place during the very first years of life, and they are shrouded in unconsciousness, which makes them nonetheless fateful. The infant does not choose, in any legitimate sense of the word, to get stuck at the oral stage or to proceed to the anal one. Yet these unconscious decisions determine the whole further course of his life.

While the particular content of the Freudian schema of development is open to criticism, and especially its curious foreshortening of the time perspective which locates all the crucial events of the individual's history in the earliest years of life, the value of the formal idea of such a schema is beyond doubt. It focuses our attention on the fact, easily lost sight of in theoretical constructions of personality, that man is a temporal being who has to pass through a series of universal crises, and whose psychic growth is inextricably intertwined with somatic events. A schema of this sort also has considerable clinical use in that it enables us to make rough estimates of *degree* of pathology. The earlier the developmental stage at which the individual got stuck or to which he regressed, and the greater the gap between chronological and psychological (developmental) age, the greater—all other things being equal—the degree of pathology. A regression to the oral stage is more serious than a reversion to the anal one, and it is more serious in a middle-aged adult than in a child or an adolescent.

The relative rigidity of the Freudian schema, the conception of which was strongly influenced by biological models of maturation, makes it subject to the charge of oversimplification. Among the attempts to fill in some of the large empty spaces of the Freudian chart,

which fails us after the individual reaches the age of five, those of Erikson (1950, 1953) are most notable.

#### CULTURAL AND SOCIAL DETERMINANTS OF ABNORMALITY

We have seen already that psychopathology cannot be understood adequately in isolation from its societal setting. In the last analysis, it is society-at-large which interprets the meaning of disease (interpreting it, for example, as demonic possession or as "natural" event), sanctions the setting and the conditions of therapeutic intervention, and decides who is to be considered as sick. Society may refuse to recognize certain pathological conditions as disease, and, in the extreme case, a man may even die of such a condition without having enjoyed the privileges usually accorded the sick (Caudill, 1953). If this is so, the disciplines studying social institutions and cultural values—sociology, social psychology, and cultural anthropology—have to be given a voice in our inquiry. Their broad range of experience will stretch our horizons and will preserve us from falling prey to the narrow parochialism of the psychiatric clinic.

*The cultural relativity of the normal* The first lesson to be drawn from the study of foreign cultures concerns the cultural relativity of the normal. Anthropology teaches us "the healthiest of all scepticisms about the validity of the concept 'normal behavior.' It can not deny the useful tyranny of the normal in a given society, but it believes the external form of normal adjustment to be an exceedingly elastic thing" (Sapir, 1958, p. 514). Social psychologists stress much the same point by talking about "modal personality" or "national character" and its relationship to the sociocultural setting (Inkeles and Levinson, 1954).

While some of the modal or preferred personality configurations which we encounter in different cultures may be reducible to each other if one uses fairly broad units of analysis, the standards of normality are definitely shown to vary between social systems. These observations of the anthropologist and the social psychologist seem to throw us into the grip of a cultural relativism which denies universal criteria of health, unless we manage to establish a new transcultural standard of normality, such as the ability to transmigrate successfully from one culture to another and to make, if need be, a viable adjustment to new and alien societal values.



Anthropologists report a great deal of anecdotal evidence that illustrates gross cultural differences in the appraisal of the malignancy of psychological phenomena. For instance, hallucinatory experiences which have an ominous, emphatically negative meaning in present-day Western societies were not long ago highly valued by some of the American Indian tribes of the great Western Plains to the point that such experiences were induced by communal ritual and were given voice in the decision of momentous personal and collective issues. Those constitutionally underprivileged enough to be unable to hallucinate tried to simulate such experiences (Benedict, 1934). Bodily tics and twitchings which our culture labels as somatic or hysterical symptoms were considered by the Apache Indians as omens which enabled one to predict future events and to which no pathological stigma was attached. So compelling is the suggestive power of the cultural setting that even the American anthropologist who made this observation failed for a long time to think of these uncontrollable tics in the context of pathology (Jules Henry, 1949). Margaret Mead tells us of cultures which consider it perfectly normal for children to make up their own idiosyncratic language, and contrasts this with the extremely suspicious attitude of American parents and teachers in the face of similarly elaborate secretiveness among their charges. Whereas we consider vomiting as the perfectly natural bodily expression of disgust, the members of the Arapesh tribe find it natural to react to disgusting situations by defecation (Mead, 1948).

Cultural anthropology considers it almost a truism that culture rather than biology establishes the standards of normality. It sees culture as the decisive agent which chooses among the manifold potentialities of the organism those to be developed, and it does not believe in the notion of a universal "human nature in the raw" which would develop "naturally" if not impinged upon by the environment (Mead, 1948). But anthropology is also sensitive to the fact that the norms proposed by particular cultures are not beyond questioning, and that they may be put in question precisely by unconsciously evolved neurotic or psychotic symptoms which in a broader perspective appear as "tacit commentaries on the validity or invalidity of some of the more intimate implications of culture for the adjustment processes of given individuals" (Sapir, 1958, p. 513).

Its broad range of experience enables anthropology to deflate some of the more speculative and generalized theses of Freudian psychoanalysis. It was Freud who popularized the notion that the members

of modern Western societies are psychologically much more complex than those of primitive, technologically immature societies, and that those regressed primitives within our own culture, the neurotics and psychotics, can be best understood by studying the psychic life of the so-called primitive people. Anthropology challenges this notion. According to Sapir, there is little hard evidence supporting this kind of reasoning. In specific instances one may even wonder if the modern Chinese or Scotchman is not psychically less complicated than members of societies which we call primitive. He writes: "It would be more than a joke to turn the tables and suggest that the psychoanalysis of an over-ritualized Pueblo Indian or Toda might denude him sufficiently to set him 'regressing' to the psychologically primitive status of an American professor's child or a professor himself" (*ibid.*, pp. 514-515).

Anthropology also questions and restricts the range of validity of certain Freudian findings. Freud had claimed universal validity for his findings concerning the Oedipus complex (hatred of the same-sexed parent and love for the parent of the opposite sex) and the latency period of psychosexual development (the period from about age 5 to puberty during which sexual development is said to come to a virtual standstill). But Mead failed to find the latency period, and a subsequent puberty crisis, with her Samoan children. Other ethnologists made similar observations which suggested that the discontinuous development of sexuality described by Freud reflects certain peculiarities of child-rearing in Western societies rather than psychological universals. As to the Oedipus complex, it appears that Freud's formulation has to be modified in order to accommodate findings in societies whose patterns of kinship and familial authority vary significantly from Western ones. Thus Eggan (1953) noted that among the Hopi Indians of the American Southwest the boy's "Oedipal" hostility is directed mainly against the husbands of his father's sisters, rather than against his father. Similarly, Malinowski (1924) claimed that among the Trobriand Islanders of the Southwest Pacific the pattern of the child's "Oedipal" conflicts was different from the Freudian one, in that the boy holds incestuous wishes for his sister (not his mother) and hostility toward his mother's brother (not his father).

If we allow the claim of anthropology that cultural factors powerfully affect the definition, interpretation, and patterning of psychopathology, we may then want to push our investigation one step



further and inquire to what extent the same holds true for various subcultures within American society. Using ecological data, we shall inquire whether certain forms of emotional disorders are more likely to be found in some ethnic or religious groups than in others. We shall focus, in particular, on the possible correlation between social status and different forms (and degrees) of psychopathology. And we shall finally present a sociological theory which interprets emotional illness as symptomatic of stresses and strains within the social system to which the sick individual belongs.

*Subcultural patterns of psychopathology* It is not always easy to separate ethnic membership from other relevant social variables, such as geographical and social mobility, which equally affect the distribution of mental disorder. This is particularly true with regard to the figures indicating higher rates of hospital admissions among the foreign-born, which in earlier studies were often correlated with biological or ethnic factors, but are nowadays interpreted as indices of the stress of acculturation. Culture conflict is known to be especially acute among second generation Americans; this factor seems to be reflected in the studies of Lemert (1948) and Malzberg (1940), based on the admittedly not very satisfactory criterion of hospitalization rates.

While the usual incidence data, based as a rule on army rejection figures and hospital records, do not differentiate among various ethnic groups, there is some evidence of subcultural patterning of pathology. It has been noted repeatedly that chronic alcoholism occurs frequently among the Irish-Americans, and rarely among American Italians or Jews, and that this observation holds for groups of comparable socioeconomic status. Among the Jews, a significant relation exists between degree of orthodoxy and frequency of drunkenness, this frequency increasing in an orderly fashion from the orthodox to the reformed to the secular Jews (Snyder, 1955). Murray (1938), on the basis of impressionistic data, noted that at Harvard the incidence of neuroticism appeared to be highest among Jewish students, and higher among Protestant than among Catholic ones. The most comprehensive of recent mental health surveys, the Midtown Manhattan Study (Srole *et al.*, 1962) did not indicate any greater amount of mental pathology among its Jewish than among its Protestant and Catholic respondents—if anything, the Jewish group showed a lower rate of “impairment.” But the study did demonstrate a strikingly greater readiness of Jews to undergo psychiatric treatment for neurotic difficulties.

Not unexpectedly, an inverse relationship is observed to exist between a tolerance for psychopathy in a subculture, and the susceptibility of its members to neurotic disorders.

Opler (1956) compared samples of New York Irish and New York Italian men who had been hospitalized for schizophrenia (a severe form of mental disorder marked by withdrawal from reality and blunting of affect), and found striking differences in symptomatology between the two groups. He attributed these clinical differences to the different family structures of the two groups. The subjects of both samples were relatively uneducated, economically deprived, most of them were unmarried (their average age being 30), and all were immigrants or sons of immigrants. Opler described the families of his Irish subjects as being dominated by the mothers, as prohibiting outward show of emotion, and as stigmatizing sexual feelings as sinful. The male offspring of these families tended to be shy and introverted in their relation with women, falling back upon fantasies as a major emotional outlet. In the Italian families, on the other hand, the father was likely to be dominant, emotions were freely expressed, and little or no feeling of sin was attached to sex. The sons tended to resent the father as wielder of familial authority. One of the more striking findings with regard to symptomatology was that overt homosexuality (which is frequently found in schizophrenics) was rampant among the Italian patients, but practically nonexistent among the Irish. However, a high percentage of the Irish subjects were diagnosed as suffering from latent homosexuality. Also the meaning of homosexuality was different for the two groups. For the Italians, homosexuality seemed to mean, among other things, an expression of hostility against the dominant father; whereas, for the Irish, fear of the formidable mother figure appeared to be a major motivational strand. It is easy to see that the Italian family's tolerance of direct impulse-expression would encourage the emergence of overt homosexuality in predisposed subjects, and that the Irish family's strictness would tend to smother it.

*Social status and mental disorder* Various studies suggest a significant relation between mental illness and social status. As far as the most severe forms of mental disorder, the *psychoses*, are concerned, a number of investigators find an inverse relationship between social status and the incidence of these disorders: rates of psychotic illness tend to increase as one goes down the status scale (Hollingshead and Redlich, 1958; Kaplan, Reed, and Richardson, 1956; Malzberg, 1956). There is some evidence to the effect that among the psychoses, manic-



depressive disorders (marked by the alternation of hyperexcitement and extreme gloominess) are more prevalent in the upper strata of society, and schizophrenic syndromes in the lower ones.

As for the milder forms of emotional disorder which we call *neuroses*, their over-all-incidence appears to be highest in the upper middle class. Hollingshead and Redlich (1958), using a five-category breakdown for social status,<sup>3</sup> found the highest rate of neurotic pathology in class II (upper middle class). They also were able to document a "class-typing" of neurotic patterns: "The class V neurotic behaves badly, the class IV neurotic aches physically, the class III patient defends fearfully, and the class I-II patient is dissatisfied with himself. Thus, we have a psychosocial pattern of community dislocation (class V), a 'body language' of pain and malfunction (class IV), social anxiety (class III), and verbal symbolic dislocation (class I-II), all called neurosis" (1958, p. 240). The Midtown Manhattan Study (Srole, *et al.*, 1962), using a sample of 1,660 adults between the ages of 20 and 59, found the prevalence of what it termed "mental morbidity" (which included all forms of mental symptomatology reflected in a thorough questionnaire) to be inversely related to socioeconomic status. There was an association of the same kind, but somewhat less pronounced, between prevalence of mental disorder and *parental* socioeconomic status.

As did Hollingshead and Redlich, Ruesch (1953) also found a preponderance of psychosomatic conditions among the lower middle class. He believes that members of this class live in a subculture of conformance and excessive repression, which leaves little room for a direct expression of anger and rebellion; hence, they are forced to fall back upon the more ambiguous language of physical symptoms. The same author attempts to explain the trend toward manic-depressive psychoses in upper-class families by the burden of a cultural tradition which cultivates an overbearing conscience, leading to unavoidable guilt feelings and depression (Ruesch, 1953).

*Fashions of psychopathology* A particularly intriguing trend is

<sup>3</sup> As main criteria of social class membership, the authors used (1) occupation, (2) amount of schooling, and (3) area of residence. Their breakdown looked as follows: Class I consisted of wealthy people living in the most exclusive area of town. They comprised about 3 per cent of the sample population. Class II was made up of upper middle-class persons of managerial and professional groups (8.4 per cent of sample population). Class III consisted of salaried white-collar workers, small businessmen, industrial foremen, and skilled workers (20.4 per cent of sample population). Class IV included semiskilled employees and some lower echelon white-collar workers (49.8 per cent of population), and class V contained semiskilled or unskilled workers of low educational status (18.4 per cent of population).

presented by the relation between historical periods and changing "fashions" of psychopathology. To remain within the more recent eras of history, it is likely, but not certain, that schizophrenia is nowadays a more common disease in Western societies than it used to be in the Europe of the Middle Ages, which seems to have been more characterized by hysterical mass phenomena, exact similes of which have not been reported in modern times. Jaspers (1953) notes that to the best of our knowledge schizophrenics never played a major role during the Middle Ages, whereas in recent centuries schizophrenic psychotics have gained great cultural prominence (Swedenborg, Hoelderlin, Strindberg, Van Gogh). Neurasthenia ("nervous fatigue"), first described as such by the American Beard, was labeled by earlier European writers an "American disease," symptomatic of the haste and empty bustle of a highly mechanized society.

In more recent times, the striking decrease of the impressive hysterical syndromes, which were the mainstay of psychiatric clinics in the days of Charcot and the younger Freud, has often been noted and commented upon. This change was paralleled by a marked increase of obsessive-compulsive and, still more recently, of psychosomatic disorders. World War I saw whole battalions of "war shakers" suffering from spastic trembling and of "shell shock" victims with hysterical paralyses and contractures. These particular forms of pathology, though, were as good as unknown during World War II, which witnessed instead an unprecedented number of gastrointestinal and other psychosomatic ailments among the psychiatric casualties.

It is well known that in certain historical eras gross psychopathology need not be an obstacle to worldly success, may even become its precondition. The great thing is to be favored with the right kind of pathology. Recent historical events have sensitized us to the fact that revolutionary periods lead to a marked ascendancy of psychopathic elements. Apparently these periods, besides offering an arena of action and a share of power to the inveterate psychopath, also encourage and solicit psychopathic license from individuals who in more settled times would have to make do with a psychoneurosis. Such times of social upheaval are apt to be uncomfortable for the psychiatrist. "In the cool periods of history we are called upon to give expert opinions on them (the psychopaths), in the hot periods—they rule over us" (E. Kretschmer).



*Emotional disease as social deviance* Sociological theoreticians who take a panoramic view have inquired into the over-all function of "motivated disease" within the social system. Professor Parsons (1951) subsumes emotional disease as a special subtype under social deviance, interpreting it as one channel of expression for social discontent and alienation. In this view, motivated illness is functionally equivalent with crime, political rebellion, religious sectarianism. All of these are expressions of stresses and strains within the social system, and constitute a challenge to its dominant values. But there is this difference: the deviance of the neurotic and psychotic is abetted by society as long as he remains within the confines of the (socially defined) "sick role." The psychiatric patient is that interesting curiosity, an officially sanctioned dissenter, but one whose challenge is attenuated by surrounding it with social safeguards, and by defining him as irresponsible, that is, as being in the grip of a "condition" for which he needs help. By these means, his sickness is largely divested of its element of social protest.

One can go along with Parsons' premise that motivated illness is a suborder of social deviance without accepting his corollary that "the apparent increase in chronic and mental illness in our society may constitute a diversion of tendencies to deviation from other channels of expression into the role of illness, with consequences less dangerous to society than other alternatives might be." (This corollary itself is based on an unproven premise, namely, that the incidence of mental disease has in fact increased in recent times in our society.)

Parsons' thesis extended to psychotherapy means that the therapist is primarily an agent of social control whose job it is to reintegrate the patient into society. In order to do so, he has to be granted certain privileges and immunities. He must be allowed to enter temporary alliances with his patients and to suspend for a while some of the basic tenets of his society (for example, emphasis on achievement). However, he can do so only with society's express sufferance, on the understanding that his privileges are revocable and that his legitimation derives ultimately from the social body at large. Like all those in steady contact with asocial or antisocial elements—the police officer, the criminal, or the military undercover man—the psychiatrist is exposed to the danger of corruption, of embracing the values of the enemies of society. Not unlike those other contact men operating at

the social periphery, he finds himself surrounded by an aura of opprobrium which tends to mitigate the impact of a potential defection. He is also beset by the opposite, more subtle, danger of doing his job as an agent of society only too well, at the expense of his patient's individuality, and of becoming a "social tranquilizer" (Szasz, 1960a) who attempts to cover up genuine social conflicts by interpreting the motivations of one or both parties in purely psychological or psychopathological terms.

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In this chapter, we have tried to clarify what psychology means by normal and abnormal. We have gone about this in two ways. First, we have examined various definitions and criteria of psychopathology. Even though we found all these conceptual approaches wanting, our examination of them may have enriched our understanding of what abnormality is by providing some associational context, if not providing us with a clear conceptual grasp.

We have then endeavored, in the second half of the chapter, to widen and solidify this context of meaning by inquiring into the concrete social setting of psychopathology. We have seen that society-at-large interprets the ultimate significance of emotional illness, and that social factors crucially affect its symptomatology and incidence. The material provided by social anthropology seems to compound confusion by underlining the cultural relativity of what passes for normal or abnormal. Stressing the cultural malleability of the individual, anthropology extends the range of variability both of the normal and abnormal; it adds to the already bewildering array of pathological phenomena. And its search for truly universal criteria of psychopathology has so far yielded no convincing results.

Yet in spite of its inability to clearly define its subject matter, abnormal psychology is somehow able to go about its business. Our task in the following chapters will be to describe the major varieties of psychopathological phenomena in our own society, and to subject them to a semblance of theoretical order.



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## Anxiety and Neurotic Constriction

### *The Phenomenon of Anxiety*

The phenomenon of anxiety is the focal point of contemporary psychopathology and, in particular, of the theory of neurosis. The major theoretical and empirical efforts to trace the etiology of neuroses point to anxiety—manifest or masked—as the instigator and mainspring of neurotic disorders. Psychoanalysis, going even further, has elevated the avoidance of anxiety to a major principle of mental functioning which is said to govern the movements of normal, as well as of pathological, psychic life.

There are those who question the singling out of anxiety as the prime mover of mental life. But even they usually agree that anxiety is an extremely unpleasant, painful affect which the instinctive hedonism of most normal and neurotic people suffers with poor grace, and tries to circumvent at almost any price. Even normal persons may invest a great deal of psychic energy in various psychological maneuvers, the major function of which is to prevent the outbreak of open anxiety. In the case of the neurotic, this defensive effort may become so excessive that little energy is left for more constructive tasks. Thus we are not far wrong in saying that those crippled by severe neuroses are psychic paupers whose lives have contracted until they revolve largely around one single (and not very heroic) purpose: the escape from anxiety.

### VARYING DEGREES OF ANXIETY

Anxiety occurs in all degrees of intensity, from the low-grade variety which may manifest itself only as a diffuse feeling of physical tenseness, through innumerable intermediate gradations marked by



increasingly severe somatic and psychic symptoms, to the shattering paroxysm of annihilating panic.

Anxiety of various degrees of intensity manifests itself most tellingly in the bodily sphere. Charles Darwin, in his *Origin of Emotions*, has described very carefully the physical symptoms of a person under the sway of strong apprehension. He mentions the violent pounding of the heart against the rib cage, the pallor of the skin, the secretion of cold sweat, the bristling of the hair, and the tremor of the muscles, and then continues:

In connection with the disturbed action of the heart the breathing is hurried. The salivary glands act imperfectly; the mouth becomes dry and is often opened and shut. I have also noticed that under slight fear there is a strong tendency to yawn. One of the best marked symptoms is the trembling of all the muscles of the body; and this is often first seen in the lips. From this cause, and from the dryness of the mouth, the voice becomes husky or indistinct or may altogether fail (quoted in James, 1892, p. 386).

Darwin goes on to describe how the intensification of fear in the "agony of terror" (what we nowadays commonly call "panic") amplifies and exacerbates these somatic symptoms. Wandruszka (1950), a modern author more emphatic and more psychologically minded than Darwin, describes the attack of panic as follows:

The eyes, wide open or shut tight with terror, the wildly, spasmodically beating heart, the failing breath, the freezing blood, deathly pallor, cold sweat and chattering teeth, the dry strangled throat, the bristling hair, the hoarse cry of terror, the shivering paralysis of the body, the shameful bankruptcy of all organs—all this the person in the agony of panic knows, without understanding it. Out of infathomable darkness anxiety strikes his heart, and his faint heart betrays and forsakes him, with his senses dizzy and his knees shaking. He sinks, and in his sinking the most horrible of all terrors arises: the dread of dread (p. 13).

If we try to extract some common features from these and other descriptions of the phenomenon of anxiety, we may seize at first upon the characteristic feeling of constriction and strangulation, noted by most observers and highlighted by the word's etymology. ("Anxiety" is derived from the Latin *angustus*—narrow, constricted; and *ango*, *anxi*—to bind, draw, throttle, strangle.) Persons suffering from angina pectoris and other heart ailments know well the dread of choking. The asthmatic, too, is anxiety prone. Internists have noted time and again that a great number of patients who complain of self-diagnosed "heart attacks" with choking sensations are really describing attacks of anxiety. The anxious person's feeling of constriction and suffoca-



tion regularly has its existential counterpart in the too narrow, "stifling" life situation (see below).

Hardly less typical of the anxious person than the somatically amplified feelings of constriction are the bodily features of muscular stiffness, muscle tremors, and deathly pallor. The anxious person can often be recognized from afar by his stiff, tense bearing. At closer quarters, he may turn out to have cold damp hands, is likely to experience chills, or may be drenched with cold sweat. Under acute stress, he may shiver with cold, and then again seethe with feverish heat. The quick alternation of deathly pallor and fiery redness will give the victim of anxiety the appearance of someone suffering from intermittent fever.

The somatic resonance of severe anxiety is such that there is hardly an organ or organ system which may not be deeply affected by it. The feeling of constriction is often allied with nausea and dizziness, and the philosophers Kierkegaard and Sartre have fastened upon these latter aspects of anxiety in their attempts to interpret its existential meaning. Closely allied to nausea, both physiologically and psychologically, is the "sinking feeling" described by Wandruszka (1950). Many an anxious person describes the experience of anxiety as a sort of teetering on the rim of a yawning chasm. Other frequently observed somatic symptoms of anxiety are vomiting, diarrhea, rapid pulse, frequent urination, irregular breathing, insomnia.

One of the more paradoxical aspects of anxiety is that the person who presents many physical and behavioral symptoms of anxiety may be quite unaware, and may deny in good faith, that he is anxious. This is more likely to be true the more anxious he is. In severe attacks of anxiety or in panic, the field of consciousness may narrow down to zero; the person does not experience anxiety any longer. At its point of greatest intensity, and sometimes long before, anxiety becomes unconscious.

The muscular tension typical of anxious people has its psychological counterpart in feelings of restlessness and tenseness which are hard to take, and which drive the victim in quest of relief to drugs and liquor, and sometimes to acts of ruthless violence against himself or others. One patient whose feeling of tenseness was localized in his right arm commented: "It would be a tremendous relief to get rid of that arm. I can exactly feel what Van Gogh must have felt when he cut off that ear." A patient of Jaspers (1963) described the urge to poke into this feeling of tension in a physical way, as one might poke a painful tooth with a toothpick.

The feeling of anxious tenseness usually goes hand in hand with pervasive feelings of helplessness and impotence which may express themselves graphically in the notorious dreams of persecution in which we are unable to move because our shaking knees fail us. A very hefty, robust-looking college student who suffered from anxiety attacks experienced himself, on the Rorschach inkblot test, as "a very small child between two adults who are swinging him back and forth." A little bit later he noticed, on the same card, "two monkeys helplessly falling through the air." And on the last Rorschach card, this theme of being passively at the mercy of alien powers found its apotheosis in the image of "two headless mice hung by their tails, tied to the stake, their front legs dangling down." Some workers have wanted to see in the complete helplessness and dependence of the human being during the first months of life the ultimate biological root of anxiety.

The characteristic feeling of constriction manifests itself in dreams in which the dreamer or some other person is confined to procrustean places, such as chests of drawers, or has to force himself, crawling, through narrow, pinching passageways. Some of these dreamers display in their waking life equally curious restrictions of moving. They may have an oddly circumspect way of twisting through doors or of moving around rooms, as if the doorways had been narrowed by invisible—or only to them visible—inner frames or as if the furniture was surrounded by translucent, sharp-angled extensions which force them to proceed with the utmost caution. One such circumspect walker reported in therapy during a period of heightened anxiety that he distinctly felt that two walls of the office had moved closer together so that the room had been transformed from a square into a sharply rectangular place. He experienced these "moving" walls as hemming him in, as sharply curtailing his freedom of movement.

The narrowed-down world of the anxious person is continuously endangered by cataclysmic blowup: explosion dreams are frequent, and so are explosion and volcano responses on psychological tests. One such patient, an applied physicist much interested in space exploration, interpreted the first Rorschach blot as a "rotating quantity of stuff that is exploding—from fracture." A little bit later he saw "a rocket blast—suggestive of violent bowel movement." A 25-year-old philosophy student suffering from chronic apprehensiveness punctuated by occasional anxiety attacks would frequently dream of rockets coming straight at him, from behind the horizon, with dull wheezy noises. These dream rockets were armed with explosive heads



most of which turned out to be duds on impact, but periodically one would explode with a cataclysmic bang which would brusquely awaken the dreamer in a state of great fright.

One fall morning, on getting up, he was aghast to find a battery of rockets ready to fire stationed only a short distance from his window. He was more dazed than scared, and expected the menacing missiles to go off any minute when he suddenly discovered that he was looking at a familiar row of trees which a recent storm or a thorough tree surgeon had stripped of much of their branches and foliage. This patient was usually in his waking life a very sober person, not given to drastic misperceptions of reality. But at this particular period, due to his forthcoming marriage which seriously challenged his constricted way of life, he felt explosive forces accumulate all around him till finally, one fine morning, an innocuous and long-familiar row of trees, revealing a slightly changed aspect, were transformed into a battery of rockets.

### *Anxiety and Fear*

It is customary in psychology to distinguish between anxiety and fear. (In actual usage, this distinction is not always adhered to, and the two words are used more or less interchangeably.) Usually, fear is characterized as having a specific, demonstrable, "fear-provoking" object, whereas anxiety is said to be diffuse and objectless, kindled by something which cannot be circumscribed or defined, by "nothing." There is a special category of fears—the so-called phobias. A phobia is a morbid, irrational fear centering around an object which is in itself harmless; it needs to be interpreted to make sense. A pretty example of such a phobic fear is that of a young woman patient who reacted with great fright to the sight of cumulus clouds; she was afraid that such a cloud would descend from the sky and swallow her!

The distinction between anxiety and fear is of clinical and phenomenological relevance. The experiential qualities, on the one hand of a concrete, object-bound fear, and on the other hand of a diffuse, objectless, or object-hopping anxiety, are perceived as different by the subject, and the two conditions are evaluated differently by the clinician. The experiencing subject and the clinical observer need not always agree in their judgment of the relative desirability of these conditions. Thus the subject is apt to experience any concretization of his apprehension, any transition from anxiety to fear, whether rational or phobic, as

a subjective relief and hence as desirable. The clinician, however, will be concerned if diffuse anxiety evolves in the direction of a phobia. To him, this change betokens the possible consolidation of neurotic structures, a turn for the worse in the subject's condition.

While the distinction between anxiety and fear is useful, it ought not to be overworked. There are transitions and areas of overlap. Anxiety shades into fear; fear is open toward anxiety. An apparent anxiety state may mask quite concrete fears. The French philosopher Emmanuel Mounier once said: "When baby cries do not accuse his metaphysical anxiety; look first for the open safety pin." Many a patient who tells his therapist that he is anxious "about nothing" turns out, on closer inspection, to be fearful of losing his job or of developing cancer.

In the theoretical attempts to clarify the meaning of anxiety two major questions arise: (1) What is anxiety really about? What is its object? Most theoreticians and clinicians agree that such an object exists even though the anxious person himself, by definition, does not recognize it. (2) What is the relationship between anxiety and fear? Which one of the two conditions is more basic, either genetically or in some theoretical sense?

Let us compare briefly three major attempts to provide answers to these questions—those of Heidegger, Schachtel, and Freud.

The existential philosopher Heidegger (1927) posits that existence as a whole is the object of anxiety: "Anxiety is anxious about being-in-the-world." Ultimately, it is the knowledge of the vulnerability and destructibility of existence—the knowledge of "the possibility of its non-being"—which is at the heart of this dread. Thus Heideggerian anxiety reveals itself as being closely akin to the vulgar fear of death.

Heidegger attaches to his anxiety also the more esoteric feature of "uncanniness." By the apprehension of the inevitability of death, man is brought to realize that he is not at home in this world, that he is only a transient guest, and this realization shakes his faith in the solidity of his world and of what he holds to be real, plunging it into the twilight of the mysteriously strange (that which might as well not be or be differently) and uncanny.

Now Heidegger holds that specific, mundane fears are nothing but deceptive concretizations of subliminal anxiety. He senses behind the most trivial fear—such as the fear of getting one's nose bloodied in a



fight—the latent existential *Urangst* (primal anxiety) which trembles about the possibility of total annihilation. In Heidegger's opinion, the existence of this primordial anxiety is the necessary precondition for the possibility of the existence of concrete, everyday fears. If man were not open to the apprehension of anxiety, he could not be touched by fear. Fear, for Heidegger, is a self-elusive, opaque by-product of anxiety which misapprehends its own nature.

A position similar in many respects to that of Heidegger is taken by the psychologist Schachtel (1959). Schachtel uses as his starting point the concept of embeddedness. To be in a state of embeddedness means to be surrounded and sheltered by what is familiar. The prototype of this state is the prenatal existence in the womb. All human growth means a separation from the state of embeddedness, and such separation, actual or threatened, arouses anxiety whenever the person is or feels helpless to cope with it. In this view, it is the partial death involved in the transition from one state of being to another which is the object of anxiety.

According to Schachtel, concrete ventures that appear to be tied up with specific fears are also fraught with unknown dangers which adhere to the mere *beyond*, to the new state of being after leaving the world of the familiar. Schachtel illustrates his meaning with the aid of a simple example:

Suppose I have learned how to swim. Now I am learning how to jump into the water or how to dive. I have already jumped a few times so that I know that nothing will happen to me, that I can deal very well with the situation, that there is no danger. Yet, I hesitate before each new jump and I have to muster my courage to risk it. What is my "fear"? Is it not really anxiety? Supposedly what I am afraid of is the object "water," or that it will not carry me. But I know very well that it will. Am I not dealing, then, with anxiety, with the nameless threat of leaving the shelter of known safety and meeting the unknown? Leaving the firm, supporting earth and venturing into a different state of being, a state of being in which many of the trusted physical relationships with the environment will be radically changed? Probably many, perhaps most fears are in this peculiar way open toward the unknown, are not only fears of a concrete event but (in varying degrees according to the general anxiousness of the person and the degree to which different situations mobilize it) at the same time anxieties about the change in the state of being which will be different from that before the event in a way which I cannot fully anticipate but which I will know only if and when I take the experience upon myself (Schachtel, 1959, pp. 47-48).

Whereas they define the object of anxiety somewhat differently, Heidegger and Schachtel agree in considering anxiety as basic, and

fear as something secondary, derived from anxiety. For them, the apparently fearful person is anxious at bottom.

For Freudian psychology, the relationship between anxiety and fear is exactly reversed. We defer for a moment the discussion of what Freud defines as the object of anxiety (psychoanalysis has had considerable trouble making up its mind on this point), or rather, for the sake of illustration, we shall provisionally use one particular Freudian definition of the object of anxiety—the threat of castration.

Now the essential point, in the context of the present discussion, is that Freudian psychology interprets anxiety as a derivative of fear, not vice versa. It is Freud's contention that in every instance diffuse, free-floating anxiety is based on, and can be traced back to, a very specific situation of fear, for example, to a childhood situation in which a little boy was afraid of being deprived of his male organ. But this particular situation was so painful that its memory had to be ejected from consciousness ("repressed"); the concrete fear was transformed into diffuse anxiety. Thus, for Freudian psychology, anxiety is fear which has lost its object.

This theoretical controversy about the relationship between anxiety and fear has practical relevance for the conduct of psychotherapy. Thus the existential therapist who takes his credo seriously will be suspicious of his patients' concrete fears which the psychoanalyst considers as perfectly normal. The former will try to bring into the open the primal anxiety, the metaphysical tremors, which he believes to hide behind the façade of mundane fear. The Freudian, on the other hand, will leave alone those (nonphobic) fears which he defines as normal, but will endeavor to come to grips with the specific threat which he postulates to be implied by diffuse anxiety. He will consider as a mere screen a patient's vague philosophical disquiet, looking for the fear of the castrating father, which he suspects to be at the bottom of it. For him, such primitive fear is an ultimate; for the existentialist, it may be only a way station on the flight from the authentic experience of anxiety. The existentialist talks of normal anxiety; the psychoanalyst recognizes only the normality of fear.<sup>1</sup>

If one wants to generalize beyond individual doctrines, one can say that intense anxiety is man's reaction to the most fundamental kind of threat, which puts into question what he deems to be his

<sup>1</sup> In their clinical language, the psychoanalysts have come to use "anxiety" as a generic term under which they also subsume fear. Thus they talk of "reality anxieties" where, strictly speaking, they ought to talk of "reality fears." When dealing with psychoanalytic concepts, the author will follow this looser present-day usage.



highest good. Depending on their divergent notions about what constitutes the highest good, various psychological theories will define the concrete nature of the ultimate threat differently. Thus Freud related primal anxiety to the threat of castration and the trauma of birth; Adler, to the uncovering of a real or imaginary inferiority which mocks the individual's will to power; Jung, to the encounter with the irrational (the archetype, the numinous); Sullivan, to the awareness of disapproval in significant others; Goldstein, to the confrontation with a task for which the vital reserves of the organism are inadequate. We have already seen that Schachtel sees the apprehension of the need, or the wish, to move beyond an old, familiar form of existence as the ultimate basis of anxiety. Heidegger, we saw, singles out the confrontation with the inevitability, the "insurpassable" task, of death.

Cameron (1951), rather than trying to identify one prototypical danger situation, isolated four general conditions likely to lead to the development of anxiety: (1) when overt escape is impossible; (2) when anticipation of unwelcome punishment is strong; (3) when opportunity to carry through an adient (approach) reaction is absent; and (4) when separation from needed emotional support is imminent or has occurred (p. 280). Cameron interprets anxiety as the consequence of the activation of emotional and physical excitement which has not been consummated or discharged by appropriate action. He gives the example of the expectant father nervously pacing the floor of the hospital waiting room, waiting for his wife to give birth. Unable to assist in the process of delivery, he is condemned to the role of an irrelevant, passive bystander. "In a literal sense he is helpless to consummate the patterned sequence of emotional behavior which his arrival at the hospital initiated" (*ibid.*, p. 278). The unconsummated, abortive reaction of emotional excitement manifests itself as anxiety.

### *Freud's Theory of Anxiety*

Freud's theory of anxiety is fundamentally a physicalistic one, based on the notion that the experience of anxiety is the subjective reflection of a flooding of the "mental apparatus" by mental stimuli which may be the result of primarily endopsychic or primarily external events.

Except for this basic notion which remained constant, Freud's theory of anxiety underwent many changes and reformulations with-

out ever reaching a really satisfactory state of completion. One usually distinguishes two main stages in this development. The transition from the first to the second stage was partially caused by a shift of theoretical emphasis, but also by a change of the nature of the empirical material under observation.

Freud's first theory of anxiety was based primarily on his experiences with anxiety neurotics and neurasthenics. Freud was struck by the observation that, with these patients, the onset of anxiety attacks or their equivalents often was closely associated with radical changes in their sexual behavior. Renunciation of intercourse or masturbation, due to external causes (loss of partner, pregnancy) or internal ones (heightening of guilt feelings), or the adoption of truncated, only partly satisfactory sexual practices (coitus interruptus) as a rule closely preceded the onset of the first anxiety attacks, and such attacks could be made to disappear quite reliably by the resumption of a more normal sex life.

These observations led Freud, at that time still much under the sway of physiology, to formulate a *toxic* theory of anxiety neurosis, which traced its genesis directly to the inadequate discharge of sexual secretions and the subsequent poisoning of the organism by these surplus products. Freud was impressed by certain similarities in the external manifestations of anxiety and of the sexual act, especially with regard to their physiological concomitants. Thus it was only natural for him to suggest that anxiety was a degraded and transmuted form of sexual energy which had not found its natural mode of discharge. "One of the most important results of psycho-analytic research is this discovery that neurotic anxiety arises out of libido, that it is a transformation of it, and that it is thus related to it in the same kind of way as vinegar to wine" (Freud, 1905, SE,<sup>2</sup> Vol. VII, p. 224).

Freud's work with more complex neuroses, such as the obsessional syndromes, soon led him to recognize the inadequacy of this notion of secretory autointoxication as a general explanatory principle. In his *second theory of anxiety*, Freud conceives of anxiety no longer as dammed up libido, as the consequence of repression, but rather as the initiator of repressive maneuvers. Anxiety is thought of as a *signal* which warns the ego of impending danger and mobilizes its defensive apparatus.

Hand in hand with this formulation of the signal function of

<sup>2</sup> "SE" refers to the Standard Edition of Freud's Collected Works published by the Hogarth Press, London, under the editorship of James Strachey.



anxiety went an increasing interest in the external danger situations which cue off anxiety.

Freud and his students (Stekel, Rank) began by identifying two prototypical danger situations: the trauma of birth and the trauma of castration. Every outbreak of anxiety in later life was supposedly caused by a partial reproduction (reintegration) of one or the other of these primal dangers. Later on, both of these traumata were subsumed under the common heading of separation anxiety. The general formula then became: every anxiety is basically separation anxiety, the prototype of which is the anxiety evoked by the trauma of birth, by the separation from the mother's body.

A combination of the developmental schema with anxiety theory then suggested the possibility of greater specificity. It seemed logical to consider that the nature of the traumatic situation of danger might vary according to the changing seasons of life. As we have seen, every stage of psychosexual development invests a specific and (for that stage) characteristic object or body region with a surcharge of libido. It is this investment which defines the nature of the basic threat. For the neonate, it is the separation from the protective hull of the mother's body which is the vital threat; for the young infant, the loss of the mother's breast or its substitute, the baby bottle; a little bit later, the loss of the physical presence of the mother, and then the loss of her psychological presence (loss of love) come to be the pre-eminent threats. For the young boy at the Oedipal stage, it is the threatened loss of his male member; for the child during the latency period, after the formation of the superego, the pangs of conscience (superego-anxiety) and loss of self-respect; still later, during adolescence, the separation from the "herd," loss of touch with the peer group, loom as the dangers to be avoided at almost any price.

Of course, there is always the possibility that a schema of this kind is too neat, too tidily systematic, to be quite true. The crude realities of psychic life, notorious for their untidiness, may not always conform to these precise formulae about the traumata specific to each developmental stage. Some qualifications and emendations may be called for. But, as so often in Freudian thought, the conception underlying the schema, if not its empirical delineation, appears to be sound.

### *Anxiety about Separation from the Mother*

In recent years, an increasing number of empirical studies have investigated one particular, interpersonal type of anxiety, namely, anxiety provoked by the separation, actual or threatened, from a beloved person. It is a curious illustration of the dominion of theory over observation that hundreds of papers, mostly speculative in nature, were written about the hypothetical trauma of birth, whose psychological reverberations are more than questionable, before some investigators began to pay close attention to observable phenomena involving the young child's physical separation from the mother as a major precipitant of intense anxiety reactions.

But beginning with Anna Freud's observations about English children separated from their families during World War II, a number of empirical studies (Bowlby, 1960; Edelston, 1943; Robertson and Bowlby, 1952; Heinicke, 1956; Prugh *et al.*, 1953; Schaffer and Callendar, 1959) have described with a great wealth of clinical detail the anxiety reactions of young children separated for some length of time, usually because of hospitalization, from their mothers. Of particular interest are the observations of Bowlby (1960) and Robertson and Bowlby (1953) in their report on normal children aged from 15 to 30 months, who had been admitted to a hospital or some residential institution where

they were cared for in traditional ways. By traditional ways we mean that the child is handled by a succession of strange nurses, mainly students, who will variously bathe, feed, and change him. The nurses will be on shift duty, and often within a few weeks most will have moved to other departments. No matter how kind each may be in her fragment of care, there will be no nurse whom he can come to know or with whom he can enter into a stable relationship. He may see his mother for a short time each day, but it may be less often. In this context a child of 15 to 30 months who has had a normal relationship to his mother and has not previously been parted from her will commonly show a predictable sequence of behavior. This sequence can usefully be broken into three phases according to what attitude to his mother is dominant. We describe these phases as those of protest, despair, and detachment (Bowlby, 1960, p. 90).

It is the initial phase, that of protest, which Bowlby finds characterized by strong evidence of anxiety. During this stage which may last from a few hours to a week or more, the child



appears to be acutely distressed at having lost his mother and seeks to recapture her by the full exercise of his limited resources. He will often cry loudly, shake his cot, throw himself about, and look eagerly towards any sight or sound which might prove to be his missing mother. All his behavior suggests strong expectation that she will return. Meantime he is apt to reject all alternative figures who offer to do things for him, though some children will cling desperately to a nurse (*ibid.*, p. 90).

Robertson (1953, 1958) described a characteristic freezing response in hospital children deprived of the presence of their mother. When he or another stranger approached, a young child would sometimes respond by suddenly becoming immobile, as if trying not to be there, though watching intently all the while. The child might close his eyes, failing to respond to any words; only a flicker of his eyelids would show that he was not asleep.

Comparable freezing responses in infant rhesus monkeys have been reported by Harlow and Zimmerman (1958). In the course of their experiments with mother surrogates fashioned from a block of wood covered by sponge rubber and terry cloth, eight baby monkeys would be introduced for short periods into the new environment of a strange room measuring 6 feet by 6 feet by 6 feet and containing a number of objects calculated to arouse their playful curiosity.

The subjects were placed in this situation twice a week for eight weeks with no mother surrogate present during alternate sessions and the cloth mother present during the others. . . . After one or two adaptation sessions, the infants always rushed to the mother surrogate when she was present and clutched her, a response so strong that it can be adequately depicted only by motion pictures. After a few additional sessions, the infants began to use the mother surrogate as a source of security, a base of operations. They would explore and manipulate a stimulus and then return to the mother before adventuring again into the strange new world. The behavior of these infants was quite different when the mother was absent from the room. Frequently they would freeze in a crouched position (Harlow and Zimmerman, 1958, p. 504-505).

Not unlike the hospitalized children described by Bowlby and Robertson, some of the infant monkeys deprived of the presence of their mother would also actively show their distress by all sorts of "protest" behavior. They "would rush to the center of the room where the mother was customarily placed, and then run rapidly from object to object screaming and crying all the while. Continuous, frantic clutching of their bodies was very frequent, even when not in the crouching position" (*ibid.*, p. 505).



That separation from loved persons is also a strong precipitant of anxiety in adults is attested by the observations of Benedek (1946) made during World War II.

### *Horney's Description of "Basic Anxiety"*

A feeling of psychological isolation is also the decisive feature of "basic anxiety" described by Horney as the dynamic core of every neurosis. In tracing the roots of childhood anxiety, Horney, unlike most orthodox Freudians, de-emphasized the importance of specific traumatic events, stressing instead the basic evil of a family atmosphere deficient in genuine warmth and affection. A child deprived of "the blissful certainty of being wanted" gradually develops an insidious, all-pervasive "feeling of being lonely and helpless in a hostile world. The acute individual reactions to individual provocations crystallize into a character attitude. . . . Because of the fundamental role this attitude plays in neurosis I have given it a special designation: the basic anxiety" (1937, p. 89). Horney also stressed the particular close connection between anxiety and repressed hostility. "Hostile impulses of various kinds form the main source from which the neurotic anxiety springs" (1937, p. 63). The emergence of hostile impulses is felt to be particularly dangerous because repressed hostility is apt to be very virulent and because the anxious person feels too weak to bear the consequences, real or imaginary, of direct aggression.

### *Neurotic Anxiety and Guilt*

Anxiety about the upsurge of repressed impulses, whether hostile or sexual, is neurotic anxiety *par excellence*. Psychoanalysis labels this sort of anxiety as id anxiety (id = reservoir of instinctual drives), and distinguishes it from reality anxiety (anxiety about threats emanating from the outside world) and from superego anxiety (anxiety about censure by the conscience, guilt). Superego anxiety and reality anxiety are neurotic only when their intensity is disproportionate to the seriousness of the precipitating event (external threat or moral transgression). The gravity of the occasion, and the degree of anxiety or guilt appropriate to it, are defined by the culture-at-large.

It is clear that the three types of anxiety do not vary independently from each other. A person constricted by neurotic anxiety is likely to be sensitized to dangers from the outside world; and the perceived

relative harshness or benevolence of the social milieu is bound to influence the fluctuations of superego anxiety.

In general, psychoanalysis expects the healthy adult to be reasonably free from any form of anxiety which is not a response to a clearly present, realistically perceived threat. Existential analysis, on the other hand, postulates that the conscious appropriation of existential anxiety (which is hardly congruent with the psychoanalyst's reality anxiety) is a necessary ingredient of ideal normality.

The existential position raises the question whether the experience of existential or ontological anxiety is really to be considered an essential feature of full-fledged humanity, or whether the exaltation of the dignity of anxiety is only the expression of a specific cultural crisis which fails to recognize its limited historical scope and wrongly proclaims itself as absolute. It is by no means clear that the ubiquity and primordial importance of anxiety demonstrated to exist in psychopathological conditions can be extended naively to the domain of psychic life in general.

### *Anxiety and Neurosis*

We are now ready to give a brief outline of a general theory of neurosis. It is a theory based primarily on Freudian formulations, the main elements of which are intrapsychic conflict, anxiety, and defense against anxiety. Its most general theoretical foundation is the psychoanalytic theory of personality with its distinction of three subsystems within the personality: (1) the ego or self which is the integrating, executive core of the personality; (2) the superego or conscience, which is the precipitate and depository of the moral-ethical attitudes; and (3) the id, the deepest, most inaccessible, and most primitive stratum of the personality, the reservoir of instinctual drives.

According to the anxiety theory of neurosis, every neurosis is an endopsychic drama with a plot of classic simplicity. There are three main actors: the circumspect, calculating ego with its regulatory and defense mechanisms;<sup>3</sup> the exuberant, explosive id with its surging impulses; and mephistophelean anxiety which spots the weak point of the ego, namely, its unheroic dislike of pain, and thereby manages to embroil it with the id.

<sup>3</sup> For the purposes of this preliminary discussion, we consider the superego as a subsystem of the ego, and do not assign independent status to it.

Under the sting of anxiety, which usually begins by being reality anxiety, the ego decides to disavow certain id-impulses (sexual or aggressive in nature) which are felt to be too dangerous, and to deny their realization. The neurotic ego feels too weak to affront the id directly. It falls back upon devious, indirect means of opposition, averting its gaze, as it were, and tending to treat the offending impulses as nonexistent. Because in the neurotic personality this conflict between ego and id does not come out into the open and hence does not reach any conclusion, the ego has to remain continuously on guard, watchful of any possible move of its opponent. The price which it pays for its perpetual fencing in of the unruly id is a loss of spontaneity and an impoverishment of personality.

This impoverishment and weakening of the ego is not yet tantamount to neurosis, but it prepares the soil for it. As long as the ego manages, by means of its mechanisms of defense, to keep the offensive impulses under control, everything is all right on the surface. But the more that psychic energy has to be invested in these strenuous defensive maneuvers, the more explosive becomes the store of instinctual energy in the id, and the greater the likelihood of a final breaching of the defensive barriers. With neurotics, the id-impulses which manage to break through usually emerge not unabashedly naked, but in more or less decorous disguise, namely, as compromise formations which express simultaneously the impulse and the only partially vanquished defense. This disguise is the concession which the impulse makes still in the moment of breakthrough to the authority of the ego and to the anxiety lurking behind it. (In psychosis where the ego is too much weakened to enforce any longer its control, impulses may emerge naked and undisguised.) The neurotic compromise formations are called symptoms.

An example of such a failure of repression with subsequent symptom-formation is that of a man in his middle twenties who shortly after marriage developed what he described as "an almost irresistible urge to urinate in a sitting or crouching position"—an urge which struck him as absurd and incongruous. While "cowering in this undignified position" he would often feel a painful burning in his urethra which he never experienced at any other time. On closer scrutiny, it turned out that this man's recent marriage and his discovery of what he took to be masculine features in his wife—such as a fluff of facial hair not noticed by him before—had activated very strong passive impulses in him, harking



back to childhood. In his dreams, his wife began to appear as a giant-sized nurse of indistinct sex, a sort of "Hercules with breasts," who would feed him and dress him. Such wishes to be taken care of had been disparaged as unmanly by his mother in his early years and since then had not dared to venture forth undisguised in his waking life. When they were reactivated by his marriage, they proceeded to manifest themselves in the (to him) so obscure, and yet (for others) so transparent symptom of his having to urinate in a woman's position. He himself later suggested that the burning pain during urination, to which no organic basis could be assigned, might have been a self-inflicted punishment for having succumbed, if only in a symbolic way, to his infantile wishes.

The precipitation of symptoms is the most apparent harbinger of the onset of neurosis. It indicates that the equilibrium between id and ego forces has been ruptured, that the ego has suffered a defeat in its policy of containment, and has been forced to fall back upon a less exposed, secondary line of defense. It depends on all sorts of imponderables whether the new position of defense can be stabilized, whether the neurosis is going to make further inroads, or whether the ego, after a period of rest, will be able to mount a counterattack and to win back part of the lost ground.

The ego's various stratagems of escape hardly ever succeed in fully eliminating anxiety. Since in neurosis the danger comes from within, and the nature of the real threat is hidden from the ego, the neurotic flight is at best only provisionally successful. The subjugated drive never fully surrenders; it can be remobilized by increasingly devious, unexpected, far-fetched stimuli, and it may finally, projecting itself onto the outside world, assail the person with satanic unpredictability among objects and situations in the midst of which he deemed himself most secure.

While symptoms are always an index of neurosis, the absence of symptoms does not necessarily indicate psychic health. We also know "symptom-free" neuroses, which are actually very widespread nowadays, and quite refractory to psychotherapeutic efforts. These are the so-called character-neuroses where the ego has managed to prevent the breakthrough of the repressed impulses by means of a surfeit of defenses. The ego has surrounded itself with a veritable Maginot Wall, with the result that the ego's original configuration is often hardly recognizable any longer. Hence, in cases of this type, it is the excess of the defensive equipment, the excessive thickness of the

"character armor" (W. Reich), which is the decisive pathognomic criterion.

A type of character-neurotic whom most therapists run across sooner or later is the "Doubting Thomas," usually an overly controlled, very dignified individual who may profess to enter therapy out of intellectual curiosity or for other lofty and specious reasons. His badge of identity is the thin sardonic smile of disbelief slightly distorting his upper lip, which may be frozen in a hardly perceptible, perpetual grin. He is invariably composed, even when telling about experiences which must have been most painful to him. The dignity of his bearing is such that a Roman Senator or a Spanish Grandee might envy him for it. If lying down on the couch he may cling throughout the hour to a militarily stiff posture of "attention!". His talk is intellectualistic and circumstantial; he considers therapy as a sort of chess game where he has to outguess and outmaneuver the therapist. Since he is more or less free from symptoms, he has nothing very pressing to talk about. Sooner or later it turns out that he has difficulties in his vocational or personal life, that he cannot hold on to a job—or to a wife. The therapist's cautious hints are dismissed with polite disbelief. It may take considerable time before the mask of superhuman self-control and urbane skepticism cracks, revealing the anxiety and dejection underneath.

The relationship between character-neurosis and symptom-neurosis is twofold: (1) Character neurosis may precede symptom neurosis; it may prepare the ground for symptom formation. The thicker the character armor gets to be, the more likely it becomes that cracks will develop and that the imprisoned impulses will find a partial (symptomatic) release. (2) The sequence can also be inverse; that is, the symptom neurosis may come first and gradually develop into a character neurosis. In this case, the resorption of the symptoms by means of an alteration in character may appear as an improvement to both the patient and those around him. This is easy to understand since the distortion of personality is less visible to the nonexpert observer, and is also felt by the patient to be less bothersome, less alien, than the preceding symptoms. But from the point of view of the therapeutic goal, the "*restitutio ad integrum*," this development means a setback, a lengthening of the road to eventual recovery.



The relative equilibrium between impulse and defense which precedes neurosis can be ruptured either by a weakening of the ego and its defensive apparatus, or by a sudden increase in the energy of the impulse, or by a combination of both. The ego can be weakened by physical exhaustion and disease, the use of dope or drugs, by somatic traumata and psychic catastrophies, such as the loss of a loved person or recurrent defeats in the struggle for self-affirmation. Sudden increases of libidinal energy are to be observed at decisive turning points of psychobiological development, especially during puberty, and also during change of life at which time a sudden flaring up of the libido is not uncommon. Such intensification of drive is undoubtedly due in part to hormonal influences. It can often, but not invariably, be brought about by the administration of sexual hormones. It can, moreover, be called forth by purely psychic factors, such as the reading of suggestive books or the viewing of erotic pictures or, more generally, by the immersion in a particularly sensuous or voluptuous atmosphere. For this reason, puberty is a particularly vulnerable period of life which often produces the first visible signs of a neurosis or psychosis. Conversely, a period of relative quiescence or consolidation of drives, such as the latency period or postadolescence, frequently coincides with a spontaneous recession of neurotic troubles or even their total disappearance. (While the distinction between ego-weakening and drive-intensification is of heuristic value, it is frequently impossible in a concrete instance to tell which of these two factors played the decisive role in the exacerbation of a neurotic conflict.)

Getting somewhat ahead of ourselves, we might want to mention at this juncture that this schema of neurotic conflict determines the two major strategies of psychotherapy. One possibility is for the therapist to side with the ego and set about to strengthen the mechanisms of defense, in the hope that the breach in the defenses can be sealed off and that the id-impulses which have forced their way into consciousness will be returned to their former state of repression. This sort of procedure we call covering-up or supportive therapy. The other half of the alternative is for the therapist to take up the cause of the id and to help emerging, up-to-then repressed impulses to a more complete, undisguised breakthrough into consciousness by tearing down the already partly damaged defenses. This does not mean, however, that he will not at the same time lend support to the ego in its anxiety-fraught confrontation with the forces of the



nether-sphere. This second approach is known as uncovering therapy. Which one of the two therapeutic methods is used in a particular case depends partly on the therapist's evaluation of the patient's ego strength—in other words, on his estimate as to how much anxiety a particular ego can endure. The choice of method also hinges on such mundane facts as the available time and the affluence of the patient. What we have described here as uncovering therapy corresponds pretty much to what the psychoanalyst attempts to do when he is orthodox.

### *The Strategies of Defense*

We must now briefly deal with the mechanisms of defense, that is, the multiple strategies by means of which the ego tries to decide the conflict with the id in its own favor. What these protective mechanisms are meant to protect against is the arousal and the perception of intense anxiety, and more particularly its arousal by unacceptable ("anxiety-linked") impulses. The measures and machinations used for this purpose are quite simple and often remarkably successful with respect to their main goal.

The mechanisms of defense operate silently and unobtrusively. They constitute a piece of unconsciousness within the realm of the ego. As soon as they are pulled into the daylight of consciousness—for example, by means of therapeutic interpretation—they lose part of their efficacy.

Their main procedure consists of falsification or distortion of outer or inner reality, important parts of which are blotted out or separated from their context so that the neurotic's reality comes to be thinly textured and shot through with holes. Such gaps are then pasted over with makeshift contrivances and dummy constructions which, on closer inspection, soon reveal their stopgap character.

A rather transparent maneuver of defense is defensive inhibition which may lead to the partial or total occlusion of the sensory organs, our bridges to outer and inner reality. The narrowing of the visual field in psychogenic scotoma (tunnel vision) or its complete darkening in hysterical blindness would be symptomatic of defensive inhibition, as would be the functional paralysis of a leg or an arm, our organs of locomotion and manipulation being equally important means of apprehending reality. One could conceive of hysterical fainting as a particularly dramatic instance of defensive inhibition. Many other defenses can be looked at as partial faintings (Fenichel, 1945).

Not always does the defensive distortion of reality proceed by the mediation of somatic structures, as in hysterical paralysis. In the majority of cases, defenses operate by means of purely endopsychic maneuvers, for example, the transformation of an originally sadistic impulse into its masochistic opposite.

As far as the effectiveness of individual strategies of defense is concerned, we can look at it from two points of view: (1) We can ask how successful a particular defense is in controlling unacceptable impulses; more exactly, how much instinctual energy it is able to contain. (2) We may want to know the price which has to be paid for this subjugation of impulses, the extent of the impoverishment of personality which is the necessary consequence of such maneuvers. In general, we can say that the protective measures which are most radical and successful in getting rid of troublesome impulses (such as repression) are at the same time the most dangerous for the integrity of the personality.

While the various mechanisms of defense, of which more than a dozen have been described, play a great part in the genesis of neurotic pathology, they are not necessarily pathogenic by themselves. On the contrary, most of them are an integral part of the psychic repertory of normal people, and they become pathological only when overtaxed or overdeveloped. To some extent, everybody uses such defenses as repression, projection, rationalization. Their presence and availability is even a precondition of psychic health. We all are in need, for the conservation of psychic equilibrium, of defensive devices and the protective filters they interpose between us and the onslaught of raw, naked reality. What it means to be denuded of adequate defenses and to be exposed to the unmitigated impact of reality is graphically illustrated by the experience of "naked horror" described by psychotics, and by the uncanny experiences of normals or neurotics whose defenses have been temporally loosened by psychotherapeutic or other intervention (for example, the taking of mescaline, lysergic acid, and similar drugs). The anxiety dreams of normals and neurotics alike contain a similar lesson. Hence it is not the presence of psychic defenses *per se* which is pathological; it is the too much or too little that matters.

#### REPRESSION

Among the various mechanisms of defense, repression is of particular importance. It is probably the most frequently encountered and the most effective form of defense because it can keep in check extremely intense impulses in the face of which the other defenses are



impotent. Therefore, it is sometimes called a primary defense in contra-distinction to the secondary defenses which often only complete the work of repression.

Repression is basically a maneuver of denial which uses the subterfuge of ignoring or "forgetting" anxiety-charged psychic contents, of treating them as nonexistent. The essence of repression lies "in the function of rejecting or keeping something out of consciousness" (Freud). Painful memories, dangerous desires, untamed affects, disturbing thoughts—they all are subject to repression. The so-called primary repressions always involve infantile experiences of a traumatic nature, which are lost to memory beyond the possibility of recall. This is to say that, in the adult, repression manifests itself largely in the guise of memory gaps.

One of the phenomena often adduced by psychoanalysts as proof both for the existence and the universality of repression is the phenomenon of childhood amnesia—the almost total forgetting, except for a few memory fragments, of the period of our life most highly charged with vivid and rich experiences. In an interesting essay, Schachtel (1959) objects to the Freudian theory which explains childhood amnesia in terms of repression: "The term and concept of repression suggest that material which *per se* could be recalled is excluded from recall because of its traumatic nature. If the traumatic factor can be clarified and dissolved, the material is again accessible to recall. But even the most profound and prolonged psychoanalysis does not lead to a recovery of childhood memory; at best it unearths some incidents and feelings that had been forgotten" (p. 285). Schachtel suggests that childhood amnesia may be due to the structure of adult memory whose categories or schemata make it an unfit receptacle for preserving the experiences of early childhood.

Not only traumatic experiences are subject to repression, but also intrinsically innocuous material which has become linked, by more or less fortuitous chains of association, with the original trauma or its attendant circumstances, which it threatens to reactivate. These secondary repressions may cause us one fine morning to forget the up-greeted a thousand times by name on the way to work, but who otherwise plays only a peripheral role in our life. On closer examination we discover that he got caught in the associative web by virtue of his having worn, on the previous day, for the first time a certain kind of straw hat which reminded us of one sported by a tyrannical teacher who was the holy terror of our first years in school.



In contrast to the primary repressions, these after-expulsions often betray themselves by the vexing feeling that we do know what we appear to have forgotten, that the name which escapes us is "on the tip of our tongue." In this, we are aware of a void which is more than mere emptiness, but which has, as it were, a specific contour of its own which calls for quite definite verbal structures. Even though the desired word still evades us, we feel with certainty that some combinations of sounds upon which we hit in our quest fit better into this curiously positive gap than others which we discard without a moment's hesitation.

Massive repressions which shut off large tracts of endopsychic reality from conscious assimilation and which alienate man from his individual life history result in a dangerous weakening and impoverishment of personality, often reflected in neurotic feelings of inferiority. Memory authenticates the identity and continuity of the self. Long ago, Plato pitied those who suffer from leaky memories and hence lose their chance of self-realization as the most unfortunate of mortals.

#### THE EXPERIMENTAL INVESTIGATION OF REPRESSION

Psychologists have made the phenomenon of repression the object of innumerable experimental investigations, most of which are an interesting paradigm of the failure of the experimental method to come to grips with clinical, and especially psychoanalytic, concepts. The reasons for the interest of experimental psychology in repression are fairly obvious. For one, the doctrine of repression is a cornerstone of the whole structure of psychoanalytic theory, and has been often designated as such by the proponents of psychoanalysis. It is always more interesting to test the solidity of cornerstones, rather than of more peripheral aspects of a theoretical system. Secondly, and probably more importantly, experimental psychologists found the repression hypothesis less outlandish than other parts of the body of psychoanalytic theory, and more assimilable to their traditional pursuits. This hypothesis seemed to bear on those phenomena of memory which ever since the classical investigations of the German psychologist Ebbinghaus in the 1880's had been the object of painstaking experimentation. A technique of exploration, or the rudiment of it—so it seemed—was already at hand. Small wonder then that experiment after experiment was set up to test the doctrine of repression. Many of these experiments had no, or little, bearing on the phe-

nomenon they were supposed to investigate. Most of the early experiments investigated the differential recall of pleasant and unpleasant memories,<sup>4</sup> and their contradictory results were interpreted some as substantiating and some as invalidating the repression hypothesis. However, the judged pleasantness of memory is not a variable directly relevant to repression. What matters is that the material to be repressed has to be associated with anxiety-evoking impulses; it may be, on the face of it, quite innocuous. Since psychoanalytic literature is quite explicit on this point, it almost looked as if the experimenters had become the unwitting victims of the very process of repression, the existence or nonexistence of which they were out to establish.

During the 1940's and 1950's, there was a second wave of experiments on repression, some of which were considerably more sophisticated with regard to psychoanalytic doctrine. Noteworthy for the ingenuity of its design, even though problematical as to its findings, was the experiment by Keet (1948). This experiment was not designed primarily to test the repression hypothesis, but rather to compare the efficacy of two methods of therapy (Freudian and Rogerian) in an experimental counseling situation. But since the criterion of efficacy was the recovery of repressed material, the experiment bears directly on our topic.

The first preliminary step of the experiment was that Keet's subjects, who had been picked from students at Columbia University, had to go through the so-called word association test. This test consists of a long list of words (stimulus words) which the experimenter calls out one by one. The subject is instructed to respond with the first word (reaction word) which comes to his mind. Certain irregularities of performance, such as a suddenly increased reaction time, reveal some stimulus words as being loaded, that is, as pointing to an area of disturbance. These words presumably are directly connected with repressed material.

After administering the word association test, Keet made up for each subject a list of six words (different for each subject) which consisted of five neutral words, to which the subject had responded normally, and one "complex" word, which had given him trouble. The subject was then required to learn this list by heart to the criterion of perfect recall. This was step 1 of the experiment proper. Immediately afterward, a second list of six words was learned, which again were culled from the association series, and which, in this instance, were all neutral (step 2). The purpose of this second step

<sup>4</sup> A thorough review of this literature is to be found in Osgood (1953).



was to speed up forgetting of the first list by the interference of intervening learning.

Keet predicted that on a subsequent recall test (step 3) with the original list, the critical word would be most likely to be forgotten, or, in other terms, to succumb to repression. This was exactly what happened. He then proceeded to try to undo this repression by a short "therapy" session of 25 minutes duration, using in half of the cases the Freudian technique, and with the others, the Rogerian one. With those who underwent Freudian "interpretative" techniques, the unavailable ("repressed") word was recovered in all cases but one, whereas in no instance of Rogerian therapy did recovery occur.

Keet could have stopped his investigation at this point, but he pushed it one step further. He instituted a second learning task, similar to that of step 1; only this time, the *reaction* word to the disturbing stimulus word (instead of the latter itself) was embedded in a list of five neutral words. (For instance, if the original disturbed association pair had been "brown—cake," the first list would have contained "brown" as the critical word, and the present one, "cake.")

Keet surmised that, if the recovery of the repressed word in the therapy session had been accompanied by some relief of emotional tension associated with the repressed material, this relief should make itself felt by the easier accessibility of the critical reaction word ("cake"). And indeed, he was able to show, in a last step, that in those cases where therapy had been successful the critical reaction word was remembered on a recall test, whereas it was forgotten by the unsuccessfully treated subjects.

Keet's experiment illustrates beautifully how much ingenuity and sweat can go into the planning and execution of a careful experiment testing clinical hypotheses. One of the more ingenious features of his experiment was that he obtained "repressible" words made to individual measure by means of the association test, whereas earlier experimenters had frequently used so-called nonsense syllables which were either fairly bare of associative context or might have carried quite unpredictable connotations for various subjects.

Unfortunately, Keet's findings themselves cannot be taken at face value, since subsequent attempts by other investigators have failed to duplicate his results. This failure is in itself instructive in that it emphasizes the necessity of repeated replication and cross-validation of experimental findings. But even if Keet's findings would have been confirmed they could not have been considered as conclusive evi-



dence since investigators have come to realize that the dream of the "crucial experiment" which establishes or destroys a thesis once and for all is only a dream. In actuality, it is only a whole context of empirical observation and theoretical formulas which gives a certain status of "truth," always provisional and revocable, to a psychological, as to any other scientific, hypothesis.

#### PROJECTION

By projection we designate the tendency to ascribe to others certain unacceptable impulses of one's own, to attribute them to something external, localized in the outside world. The radical use of projection as a defensive device is apt to have very ominous consequences. It distorts social reality beyond the possibility of dealing effectively with it, and can be seen in its full pathological flowering in the deluded paranoid patient who, as one such patient put it, "can read the filthy minds of others by direct thought transmission," and who is scared lest they destroy the lily-white innocence of his own heart by some satanic electronic device.

It is probable that the infant experiences at first his internally aroused sensations, such as hunger pangs, as something alien, originating in external space—"out there"—before he gradually detaches these projected pulsations from the outside world and, retracting them inside his psychobiological sphere, recognizes them as his own. Even as healthy adults we retain this natural tendency to ascribe our own intolerable impulses at first to our fellow man. This is often the first step on the circuitous road toward self-knowledge. The discovery that we suspect Machiavellian motives or a secret depression behind any passerby's smile will make us stop short one day, forcing us to recognize these qualities as hitherto ignored parts of our own make-up. We also make use of projection in the nighttime world of dreams where we often experience endopsychic events as if taking place on a stage or flitting past on a movie screen.

In a sense, all our perceptions can be said to contain an element of projection in that we never come face to face with "naked reality," but always see it through a veil of individual or collective myths which can be compared to projective systems. We are free to rid our perceptions of this or that form of mythology, to shed a particular bit of the translucent veil that has ceased to be adequate to our vision of reality, and to replace it by a more commensurate, less concealing one, but it is beyond the

realm of possibility to do without such veils altogether. Whenever we think that our laborious efforts have isolated a fragment of seemingly raw reality, we are sadly mocked by the discovery that we have only invented a new interpretive image. This appears to be true of all philosophical and scientific discoveries which seemingly free us from the imprisonment by superannuated myths. The relief is only temporary, and after a short time, they in turn are recognized as a new mythology. The history of psychoanalysis is instructive in this respect.

The projections of normals and neurotics differ from those of paranoid psychotics in that they can be modified by experience, whereas the projections of paranoids are characterized by a stolid imperturbability and incorrigibility. They are impermeable to the demonstrations of contrary experience and rational argument; they even seem to feed on them. Every new event, no matter how incongruous, supplies new raw material for their delusions. The unshakability of the paranoid in the face of everything mimics the rock-like unassailability of a certain type of religious faith, and may even become a source of envy for those who, torn by doubt and despair, roam the road to Damascus.

#### REACTION FORMATION

We speak of reaction formation when an unacceptable impulse conceals itself behind its apparent opposite, as, for example, when an anal predilection for mud and dirt is screened by an exaggerated zeal for cleanliness.

Such reaction formations play a key role in the Freudian alchemy of libido transformations in that they designate not only a method of neurotic defense, but also an important mechanism of normal personality development. It is quite typical for this development to proceed by such discontinuous shifts which have much in the nature of reversals. Not infrequently an outlived, antiquated character trait is replaced by one which is pretty much the opposite of its predecessor. The sequence may look quite similar to the one described above (intense anal interests superseded by a new emphasis on order and cleanliness), hence the distinction between normal growth and pathological distortion of personality is sometimes difficult to make in the presence of such interest reversals. Everything hinges on quantitative nuances, that is, whether such traits as helpfulness or independence, which in themselves are certainly not pathological, are overemphasized or over-

developed. Such exaggerations betray the presence of a reaction formation, indicating as they do that the superseded impulse has been less outgrown than forcibly repressed and remains virulently active in the unconscious. Reaction formations sometimes combine with projections to a highly explosive and demonic mixture which is known as fanaticism.

#### INTELLECTUALIZATION AND RATIONALIZATION

Closely allied mechanisms are intellectualization and rationalization which bend thought to their purposes, degrading it to a tool of narrowly defensive interests.

By intellectualization we designate the tendency to divest affect-laden problems of their emotional charge by repression of the affect, and to transform them into purely intellectual riddles which do not seem to involve the deeper layers of personality. During treatment, the intellectualizer will be wont to speak at great length about his "Oedipus complex" and indulge in subtle speculations whether it is of the regular or inverted variety, or whether Freud's formulas apply to his case at all. He will not allow himself really to feel the intense hatred for his father or the incestuous wishes towards his mother hidden behind all this talk.

The defense of rationalization perverts reason by forcing it to become the champion of basically irrational interests and passions, and to fabricate pseudo-reasons for actions and attitudes the real motives of which do not bear inspection.

Intellectualization and rationalization are the favorite defenses of the intellectual whose neurotic trends are likely to enlist his intellect for defensive purposes. He is always beset by the temptation to enhance his sense of power by superimposing upon reality a net of superrationality which makes it appear more predictable and manipulable than it is. This pseudorationality is comparable, in its function, to the black magic of primitive peoples, and is about as effective. It differs in this from the genuine rationality of modern natural science which owes much of its impetus to the same will to power, but which discovers effective causal relationships, and which, at least as represented by its more acute spokesmen, respects the limits of causality and rationality. That the neurotic "need for causality" represents only the stage of hypertrophy of a primary, universal, and spontaneously emerging cognitive impulse is suggested by the endless "whys?" and the tireless intellectual curiosity of small children, which, according to psychoanalysis, has its ultimate source in the effort to solve the



riddles of sexuality. More fundamentally, psychoanalysis shares the Schopenhauerian notion that mind in its cognitive aspects is essentially an instrument in the service of self-maintenance and survival. Freudians assert that the mind's main function is to compute various odds and to calculate in advance the probable outcome of diverse courses of conduct by means of mental trial actions. Neurotic misuse of cognition would then consist in lapses of this primary function, in reason's being weighed down by having to plead the special interests of various endopsychic pressure groups, at the expense of the superordinate interests of the total personality.

#### OTHER DEFENSES

Let us briefly enumerate a few other defenses which are of major clinical import. We have already mentioned *regression*, the falling back from a more mature to a genetically more primitive, infantile mode of behavior. In addition there are *conversion*, the transformation of psychic excitement into physical symptoms (a theoretically obscure and questionable notion); *displacement*, the transfer of an instinctual interest from one object to another; *isolation*, the separation of fragments of experience from their historical and emotional context with the subsequent blunting and strangulation of the attendant affect; and *denial*, the active negation of threatening aspects of reality. Adlerian psychology has stressed the mechanism of *overcompensation*, the attempt to cover up and overcome real or imagined inferiorities by means of overwrought and one-sided, but often successful, efforts. The classical example is that of Demosthenes, the stutterer who became one of the greatest orators of Greek antiquity.

Neurotic overuse of defenses may manifest itself largely by marked rigidities of behavior which Horney (1937) designated as "neurotic trends." She described as one of these trends the neurotic craving for affection with its constricting demand on the "loved" partner that he be perfect and perfectly loving, at all times. This hunger for affection seizes upon everything, including sexuality, as a tool in order to gain desperately needed reassurance, which for a while may allay the ever-threatening basic anxiety. Neurotics driven by this particular need will try to satisfy and please everybody. They will osmotically adopt their companions' opinions, afraid to contradict or vex anybody lest their psychic income of recognition be reduced. Another neurotic trend, of particular importance in our society, is the neurotic quest for power which is the propelling motive of many managers, politicians, and other social leaders. The neurotic need for power serves,

in the last analysis, as a defense against the unbearable threat of helplessness. It is distinguished from what may be a healthy desire for the exercise of authority and power by a certain pompousness of style, by the tendency to surround oneself with flunkys and yes-men, by the inability to brook any signs of independence in others. In the life of those who hoard power, sexuality, too, is apt to become a means of self-aggrandizement. Every sexual encounter is twisted into a fight for predominance. The craving for power was singled out by Alfred Adler (1927) as the mainspring of human behavior.<sup>5</sup>

A schematic presentation of the various strategies of defense, such as we have endeavored to give on the preceding pages, will be misleading unless one destroys the neatness of the schema at the end of the presentation. It is important to point out that in the concrete clinical case one usually encounters some overlap, and much commingling, of the various defenses. Hardly ever does one find a "pure strain" of a given defense. It is fortunate, however, that by and large every form of neurosis and psychosis is associated with certain preferred and characteristic modes of defense. Hence the clinician, when confronted with a phobic person, knows that he has to be on the lookout for displacements; in the case of an obsessive, he will expect to find a predominance of isolation and intellectualization. Since it is rather useful during a voyage of discovery to know from the outset what one is hunting for, a thorough knowledge of the various mechanisms of defense, and of their correlation with specific clinical syndromes, is of great importance to the psychotherapist.

\* \* \*

In this chapter we have attempted to understand neurosis and neurotic constriction as the result of the defensive avoidance of basic anxiety. This basic anxiety, we have seen, is something which endangers the very foundations of an individual existence, which is so threatening that the option of facing it squarely does not even exist. To repeat it once more, the crucial decisions concerning health and neurosis are made in early childhood, and they are unconsciously arrived-at decisions, not matters of deliberate choice. The young child who feels threatened in his very survival by his mother's going away does not choose to avert his gaze from the catastrophic implications of this loss. His defenses come into play with the automatic inevita-

<sup>5</sup> Both Adler and Horney were only partly successful in their attempts to make a clear distinction between normal and neurotic strivings for power.

bility of a gagging or breathing reflex as soon as his anxiety becomes unbearable.

An experience involving intense fear and pain *need* not be pathogenic; it becomes so only if it results in the defenses of a vulnerable personality being frozen in such a way as to rescind decisively the conscious appropriation of an important part of internal or external reality, as, for instance, if the mother's going away induces the child to play down or deny henceforth his need for loving intimacy. On the other hand, a childhood history fairly free from major traumatic incidents can yet be the antecedent of injurious neurotic (and psychotic) developments if the general family atmosphere was one of nonacceptance and emotional insecurity.

In the chapters that follow we shall see how the variations of the interplay between neurotic anxiety and pathogenic defense are reflected in the several clinical syndromes.





# 3

## Psychoneuroses I: Traumatic Neuroses, Anxiety States, and Phobias

### *The Classification of Emotional Disorders*

#### THE DIAGNOSTIC SCHEMA

Before launching upon the discussion of the various clinical conditions, we need to present an outline of the classificatory schema we propose to use:

- I. Psychotic Disorders (Psychoses)
- II. Neurotic Disorders
  - A. Psychoneuroses
  - B. Psychosomatic Disorders
  - C. Character Disorders

The great division in the field of abnormal psychology is between the psychoses or major mental illness and the neurotic conditions. The *psychoses* are the most severe form of emotional illness. They are characterized by such symptoms as loss of contact with reality, incoherence of thought, blunting or inappropriateness of affect, bizarre mannerisms, grave disturbances of mood. A great number of psychotic patients, unable to function in everyday life, need the special protective environment of a hospital. We shall deal with the psychoses and their subdivisions in Chapter 7.

The *neurotic* conditions are less severe disorders in which there is no gross personality disorganization. The afflicted person is usually

able to fulfill the normal demands of everyday life even though he may find them burdensome and though his sphere of activity may be relatively reduced. The three major subdivisions under the general heading of neurotic disorders are defined as follows:

1. In the *psychoneuroses*, one or several neurotic symptoms, such as anxiety, phobic fears, or haunting irrational thoughts, dominate the clinical picture. They are symptom neuroses in the narrow sense of the term.
2. In *character disorders*, such neurotic symptoms are either lacking or play a minor role. They are characterized by pathological distortions of the basic personality pattern as manifested in the conduct of life. In this category belong the neurotic characters, also neurotic criminals, alcoholics, sex deviates, drug addicts.
3. *Psychosomatic disorders* are characterized by somatic symptoms associated with emotional tensions, frequently involving structural damage in organs or organ systems. Examples are peptic ulcer, mucous colitis, essential hypertension, psychogenic asthma.

Within the category of the psychoneuroses, we distinguish the following subdivisions:

## II A. Psychoneuroses

1. Traumatic neuroses
2. Anxiety states
3. Phobias
4. Hysterias
5. Obsessive-compulsive conditions

*Traumatic neuroses* are distinguished by the manner in which they are precipitated. They are neurotic reactions to unusually severe stress, with varying symptomatology. War neuroses precipitated by exposure to particularly stressful combat duty are exemplary.

In *anxiety states*, manifest anxiety is the main symptom; in *phobias*, it is the presence of the already described irrational fears. *Hysterias* are further subdivided into conversion reactions which exhibit somatic symptomatology (hysterical paralysis or blindness) and dissociated states which are characterized by a loss of integration and autonomous functioning of parts of the personality (amnesia, multiple personalities). In *obsessive-compulsive* neuroses, the characteristic feature is the person's feeling forced to think certain thoughts and to execute certain acts, which strike him as absurd, but whose compelling power he cannot escape.

## PROBLEMS OF DIAGNOSIS

This taxonomic schema looks fairly tidy, but it is not; nor are the clinical realities which are supposed to be pigeonholed in its various categories. For one, the schema is sadly lacking in any superordinate principle which would allow us to order it in a systematic or hierarchical fashion. It is a mere catalogue, formed by the enumeration or juxtaposition of various categories which might as well be arranged in a different order. The criteria by which the several categories are established are extremely heterogeneous: somatic phenomena (conversions, psychosomatic illness), disturbances in mood (manic elation, depression), manner of precipitation (traumatic or nontraumatic), presence or absence of certain affects (anxiety states, phobias), alterations in the state of consciousness (hysterical semitrance), loss of the feeling of freedom and spontaneity with regard to one's psychic processes (obsessional thoughts). One hardly expects such a heterogeneous schema to be free from overlap—which ideally it ought to be, especially for epidemiological investigations—and, in fact, it is not. Since several of the above criteria may apply in the same case, since many a patient, for instance, shows at the same time signs of manifest anxiety, of depressive discouragement, of obsessive guilt, and of somatic dysfunction, the task of classification is often rather difficult. The experienced clinician works with a more or less explicit typology which guides his diagnostic decisions in terms of the relative preponderance and the patterning of various symptoms. Even so, the fluidity and ambiguity of many actual cases is such as to make the job of classification an ordeal for the punctilious clinician.<sup>1</sup>

## THE PSYCHOANALYTIC HIERARCHY OF NEUROTIC PATHOLOGY

Psychoanalytic authors have attempted to systematize the nosology of the psychoneuroses. They suggest that there is an orderly sequence of increasing pathology from the anxiety states through the phobias to the so-called defense neuroses (hysterias and obsessive-compulsive reactions). The main criterion of severity of pathology is the elaborateness of defenses. (The more elaborate the defenses, the more pathology.) Thus in anxiety states where manifest anxiety itself is the main symptom, the defenses are usually less elaborate than in the

<sup>1</sup> Some clinicians suggest doing away with classification and diagnostic labeling altogether. But the need for order tends to reassert itself sooner or later, and so does the wish for deductive and inductive knowledge, which, based on classes of similar cases, presupposes some sort of classificatory system.



phobias where feelings of anxiety are still present, but have undergone a defensive transformation by coalescing with phobic objects or situations. The psychoanalyst says that anxiety has been "partly bound up" in the phobic symptoms. In hysterias and obsessive-compulsive neuroses, this defensive binding of anxiety is carried one step further in that now anxiety as such is hardly visible any more; it has been transformed, by means of symptom formation, into latent "frozen" anxiety.<sup>2</sup>

Within the domain of the defense neuroses, psychoanalysis uses as an additional criterion of severity of pathology its scale of psychosexual regression. Obsessive-compulsives are said to regress to an earlier stage of psychosexual development than hysterics; hence the former are adjudged to be sicker. The psychoanalytic hierarchy of pathology in the field of the psychoneuroses then goes as follows (those at the top being the more benign conditions):

Anxiety states

Phobias

Hysterias

Obsessive-compulsive neuroses

This scale seems to reflect much clinical experience concerning the treatability and prognosis of the various syndromes. Many clinicians would agree that among psychoneurotics, by and large, obsessive-compulsives are most refractory to treatment, and that the prognosis for anxiety neurotics is likely to be most favorable. But this is only a rough generalization of limited validity, which needs to be modified for many individual cases.

*Multidimensional schemas of diagnosis* Some mathematically inclined investigators suggest abandoning the present class schema of taxonomy which, according to them, fails to take into consideration that all "the so-called psychiatric syndromes . . . are present in all persons to some degree. All patients may be, to some degree, depressed, suspicious or disorganized in their thinking" (Lorr, 1961, p. 19). Lorr suggests replacing the present schema by a multidimensional system where each individual case would be allocated a place in terms of his standing on various relevant variables (anxiousness, depression, sus-

<sup>2</sup> This does not mean that anxiety has been exorcised. It can be easily remobilized if one interferes with the symptom. A neurotic suffering from a handwashing compulsion who suddenly decides to stop his ritualistic practices will almost invariably experience a painful anxiety attack.

piciousness). Inspection of clusters could then lead to the delineation of classes of patients, which in some cases might be quite different from the presently existing ones. Lorr *et al.* (1955) have used the statistical technique of factor analysis in order to analyze the data obtained from 423 male psychotics, each of whom had been rated on no less than 55 variables. They extracted eleven "factors" (which are basically columns of numbers expressing correlations between the variables used) to which they assigned such verbal labels as "retarded depression versus manic excitement," "motor disorganization," "restiveness," and so forth. These eleven factors were then arranged in three groups or clusters of factors, two of which corresponded to the usual diagnostic subdivisions in the area of the psychoses (schizophrenic and manic-depressive disorders), whereas the third cluster appeared to reflect "disturbances of temperament or character which may be observable in non-psychotic as well as in psychotic patients." It ought to be pointed out that this sort of statistical analysis, in spite of the wealth of the raw data used and despite its impressive mathematical apparatus, is vulnerable to criticism. For one, the accuracy and the selection of the original data, on which the whole elaborate structure is built, is always subject to question; secondly, the crucial steps of labeling factors, of grouping them in clusters, and of giving verbal labels to these clusters involve major interpretative decisions which are handled differently by different investigators.

A two-dimensional schema of diagnostic analysis for neurotic conditions has been suggested by Eysenck (1961, 1957). The two dimensions used by this author are those of "extraversion-introversion" and of "neuroticism." By means of various test performance and behavior ratings, each person can be assigned a numerical score on these two variables and thus be placed on the two-dimensional continuum. According to Eysenck, obsessive-compulsives, anxiety neurotics, and depressives are high on introversion and neuroticism, whereas hysterics fall into the extroversion-neuroticism quadrant of the schema. Those diagnosed as mixed neurotics tend to be high on neuroticism and intermediate or neutral with regard to extraversion-introversion. One of the alleged advantages of such a diagnostic continuum is precisely that it easily accommodates cases with mixed symptomatology, which are embarrassing for a schema that relies on discrete categories. And a two-dimensional continuum ap-

pears superior to a one-dimensional one because it reflects more adequately the known complexities of clinical reality, for instance, the fact that there is a pronounced polarity between hysterical and obsessive-compulsive syndromes.

It is interesting to note that in a study carried out by Hildebrand (1953) along the lines suggested by Eysenck, anxiety neurotics scored higher on neuroticism than obsessive-compulsives, which is in direct contradiction to the psychoanalytic schema outlined above and to much clinical lore. It remains to be seen whether two- or multidimensional schemata of diagnosis will bear theoretical and practical fruit.

### *Traumatic Neuroses*

Traumatic neuroses are neuroses precipitated by extreme stress. The traumatizing stress is frequently of relatively short duration. The classical example is the war neuroses precipitated by harrowing combat experiences. The traumatic neuroses of civilian life are exemplified by the so-called accident neuroses, triggered by the shock of a dangerous accident (car collision, airplane crash). The characteristic feature of traumatic neuroses is that they are reactions to relatively circumscribed external events of catastrophic intensity.

In a certain sense, every neurosis presupposes external stress. Neurotic pathology is always due to the interplay of endopsychic predisposition and external hurt. No neurosis is entirely endogenous because no subject is entirely worldless. Thus, to some extent, every neurosis can be said to be of traumatic origin. However, we usually reserve the label "traumatic neurosis" for those conditions where the precipitating stress is unusually severe. We do not speak of traumatic neuroses when a relatively trivial incident (for example, the loss of a tooth, the denting of a car fender) triggers neurotic symptom-formation.

#### WAR NEUROSES

Among the neuroses of traumatic origin, the war neuroses are the most dramatic and have been studied most thoroughly. Hence we shall focus here on this type of traumatic neurosis.

In the literature, one usually finds a distinction made between the acute combat reaction (combat exhaustion) and the neurotic syndrome proper, which may, but need not, crystallize out of the acute



reaction. The latter is the immediate response to intense combat stress and vanishes spontaneously soon after the stress is removed. War neuroses, on the other hand, are characterized by the fact that symptoms do not disappear promptly and automatically once the person has left the danger zone.

*Combat exhaustion* The acute combat reaction is characterized by irritability, insomnia, and sensitivity to noise. The victim is jumpy, feels overtired, and is unable to relax. He complains about loss of appetite, begins to chain-smoke, and, if liquor is available, drinks to excess. His face shows a curiously closed and resistant expression. He finds everything too burdensome and heavy and throws away pieces of equipment, food, weapons, and even valuable personal property. Letters from home remain unread. He is in anguish about losing sight of his fellow soldiers (J. E. Meyer, 1961). A typical case of combat exhaustion is described by Bartemaier *et al.* (1946): "A very weary, dirty, and dishevelled man sitting with his head in his hands, trembling and jerking, muttering over and over, 'Shells and tanks, shells and tanks' or 'It was the 88s, Doc, the 88s all the time' or 'I can't stop shaking.'"

Various somatic symptoms—the same ones we have encountered as concomitants of the anxiety reaction—usually accompany combat exhaustion: vomiting, diarrhea, tremors, headaches, dizziness, nausea, heart trouble ("soldier's heart"), frequent urination, cold sweat. There is, as a rule, a pronounced loss of weight.

Not infrequently, an extreme apathy appears ("old sergeant's syndrome"). The soldier suffering from combat exhaustion begins to feel divorced from reality. The events around him do not "register" any more or, rather, he registers them in a remote, detached manner. Jaspers (1963) quotes a German soldier of World War I describing his reaction to prolonged trench warfare:

We were reduced to having to "wait and see" although we were in immediate danger. Our minds froze, grew numb, empty and dead. Every soldier knows such an experience if he has to lie still under heavy barrage. One gets so tired, so utterly weary. Thoughts crawl, to think is such a labour, and even the smallest voluntary act becomes painful to perform. Even talking, having to reply, get one's thoughts together, jars on the nerves, and it is felt as a sheer relief to doze and not have to think of anything or do anything. This numbness may indeed grow into a dreamlike state, time and space disappear, reality moves off infinitely far, and while one's consciousness obediently registers every detail like a photographic plate, feelings waste away and the individual loses all touch with himself. Is it you who sees, hears and perceives, or is it only your shadow? (pp. 368-369)

Later on, the same witness reports how the apathetic soldier in the trench may become increasingly narcotized by the monotony of uninterrupted droning artillery noise, how his eyes slowly close, and "right in the middle of the deadly uproar he falls asleep" (*ibid.*, p. 369). Similar observations of combatants falling asleep in the midst of a roaring battle have been reported during World War II.

Strictly speaking, the term "combat exhaustion" is a misnomer, at least insofar as it refers to physical exhaustion. Some military psychiatrists during World War II were impressed by the fact that man seems to have an "almost absolute tolerance" of exhaustion (Bonhoeffer, 1947). An American infantry division in Normandy which had gone through more than 50 days of uninterrupted combat had only 1.7 per cent of cases which could be diagnosed as genuine states of exhaustion (Nesmith, 1947).

*A case of war neurosis* While acute combat reactions are to be found in the most normal of soldiers if the stress to which they have been exposed has been severe enough, these reactions seem to crystallize into chronic war neuroses only in psychologically vulnerable, predisposed individuals. Erikson (1950) gives a good case history of a war neurosis developing out of a combat reaction—a case which clearly shows the interaction of specific wartime stress and neurotic predisposition. The subject was a man whose character structure was more rigid than average, and who hence was more neurosis-prone than the average soldier. He had, however, been asymptomatic up to the harrowing war experiences to be described, and might very well have managed to remain so had it not been for a concatenation of extreme pressures unlikely to be encountered in the course of ordinary life. In what follows, we slightly condense and paraphrase Erikson's account:

The hero was a young teacher in his early thirties who was discharged from the armed forces as a "psychoneurotic casualty." His main symptom was an incapacitating headache which had no demonstrable organic basis. A postwar interview in a VA clinic elucidated the circumstances surrounding the onset of the illness:

This man had been lying with a group of marines, just ashore in the pitch darkness of a Pacific beachhead within close range of enemy fire. They were helplessly exposed to damnable sniping from nowhere and lacked adequate support from the Navy artillery. These men were not accustomed "to take it lying down" and a suspicion that the "brass" might consider them expendable began to eat at their entrails.

The future patient served as an unarmed medical orderly among these tough, combat-hardened veterans. He felt immune to the slowly rising wave of rage and panic among the men and he looked upon them with

condescension as a bunch of griping kids. He felt neither fear nor hate for anyone, nor had he ever. The reason that he had become a medical soldier was that he could not bring himself to carry an instrument of extermination, a gun. It was good now to show that he could take it and more, that he could help these boys to take it too. Throughout most of the night he kept close to his medical officer, a good man like himself, a man whom he could look up to and admire.

The patient never quite remembered what happened during the remainder of the night. There were only isolated memories, more dream-like than real. He claims that the medical corpsmen were ordered to unload ammunition instead of setting up a hospital; that the medical officer, somehow, became very angry and abusive; and that sometime during the night somebody pressed a submachine gun into his hands. Here his memory became a blank.

The next morning the patient found himself in an improvised field hospital with a severe intestinal fever, and after another harrowing night, in which he and his fellow-patients were helplessly exposed to enemy bombing from the air, he was evacuated. Aboard the evacuation ship he showed the main symptoms of what was later diagnosed as a war neurosis, namely raging headaches, jumpiness, and an extreme apprehension of possible metallic noises. The headaches, in particular, followed him into civilian life and made his existence miserable from then on.

In trying to elucidate the history prior to the onset of the neurosis, Erikson focused on the fact that this man, who never swore, drank, or smoked, who did not bear arms because he could not feel angry at anyone, was "too good to be true." As is always the case, this exaggerated virtuousness had a history. His free associations led through a not-too-circuitous path from metallic noises to his mother, and it turned out that he had not seen his mother since he was 14 years old. His family had then been on an economic and moral decline. He had left home abruptly when his mother, in a drunken rage, had pointed a gun at him. He had grabbed the gun, broken it, and thrown it out the window. Then he had left for good. He had secured the secret help of a fatherly man—in fact, his principal. In exchange for protection he had promised never to drink, swear, or to indulge himself sexually—and then, never to touch a gun. He had become a good student and a teacher and an exceptionally even-tempered man, at least on the surface, until that night on the Pacific beachhead, when amidst the growing anger and panic of the men, his fatherly officer had exploded with a few violent oaths, and when immediately afterward somebody had pressed a submachine gun into his hands (Erikson, 1950, pp. 34-37).

In his interpretation of this sketchily presented case, Erikson indicates that holding a gun had become such a focus of traumatic anxiety because for this patient a gun symbolized his family's downfall and all the angry and ugly things which he had chosen *not* to do. The war situation must have been, beyond its real dangers, particularly threatening to him because it also was a source of constant temptation to



give in to the infantile (aggressive) urges which he had so rigidly held in abeyance. And when the very superiors on whom he had relied ordered him (or so he thought) to break his symbolic vow not to touch a gun, his ego structure collapsed. To be sure, this structure had been rigid and hence vulnerable to begin with, based as it was on the denial of strong aggressive urges, but it is entirely conceivable that it would have carried him without major mishap through the lesser provocations of civilian life. It was the war situation which brought out the hidden flaw in this man's personality and thus precipitated the neurotic symptoms.

Another aspect of this case is instructive. Grinker and Spiegel (1945) and other authors have reported that one of the main features of traumatic neuroses during World War II, in contrast to those of World War I, was a nagging sense of guilt. A large number of these patients accused themselves of imaginary sins of omission, and expressed the belief that, if they had done everything humanly possible, they could have saved some of their buddies. Sometimes they felt that others had been killed in their stead, had "died for them." Many of the neurotic sufferings to which they clung tenaciously expressed their attempt to expiate this imaginary guilt and the secondary guilt feelings provoked by their "desertion" on the grounds of illness. These men could not bring themselves to regard their neurotic illness as a legitimate disease. They were the unwitting proponents of a moral interpretation of neurotic disorder. This was also true for Erikson's patient who felt "shot through the head" by excruciating pain whenever he definitely was better, or rather whenever he became aware of having felt well for some time without noticing it. It is to be assumed that these neurotic guilt feelings drew their sustenance and peculiar strength from childhood conflicts which were never adequately dealt with.

*The meaning of posttraumatic symptoms* What other theoretical lessons are to be drawn from the war neuroses? For one, these neuroses are often particularly transparent as regards the mechanism and the meaning of symptom formation. Much more readily than with other more intricately textured neurotic conditions, it is possible, in the case of war neuroses, to trace a connection between symptom and precipitating event. A very simple example is offered by Kardiner (1959). He described the case of a veteran of World War I, who was only able to sleep when he would lie prone in bed with his hands over his head. In the course of the anamnesis, it turned out that this man had been gassed during the war. He had been taken by surprise

and failed to "take cover." His prone posture was a belated "taking cover" under the influence of which he felt sufficiently protected to fall asleep. Thus the compulsive sleep ritual was a belated, wishful correction of a traumatic situation, an unconscious restitution for a sin of omission which had endangered his life.

Often the neurotic symptom, especially if it is hysterical, appears to express a very direct identification with a wounded or killed friend or enemy, perhaps as a token of expiation. Strecker (1952) reports an observation about a group of soldiers who were exhibiting odd twisting, writhing, convulsive movements of their abdominal muscles. Later it turned out that these curious symptoms sometimes followed the bayoneting of an enemy soldier through the belly. Klein (1948) observed a 20-year-old sailor on Iwo Jima who reported sick with an anesthesia of both his lower arms and hands. It transpired that this man, while burying the narrowly crowded, mutilated corpses of American and Japanese soldiers, had suddenly come upon the severed arm of his best friend.

Some authors stress the "secondary gain," the indirect advantage, to be derived by the patient from falling ill. This gain, while not consciously anticipated, may be substantial. In the case of a paralyzed hysteric, it might consist of the increased care and attention paid to him because of his infirmity. In the case of a war neurosis, this secondary gain, involving the removal from the battle line, can be literally lifesaving. It was repeatedly noted that dramatic and crippling symptoms would suddenly recede or vanish once it was certain that the patient would not have to return to combat duty. (In some other cases, discharge from active duty would aggravate the symptoms, presumably because of a heightening of guilt feelings.)

Another theoretical question which war neuroses raise, without providing a firm answer, is the following: What constitutes a traumatic event? Or, more specifically, what are the circumstances which define a condition as traumatic? It seems fairly clear that these circumstances can vary from case to case. Often, undoubtedly, as with the medical orderly described by Erikson, they are circumstances which specifically invalidate the neurotic premises on which a whole life pattern is built. Sometimes it may be a very unlikely, accidental concatenation of circumstances—as unlikely as the chance discovery of the combination of a safe—which unlocks the door to a secret weakness of the personality and thereby precipitates acute symptoms.

*A note on the epidemiology of war neuroses* It has often been noted during World War II that anxiety reactions and their somatic

concomitants constituted a great majority of the war neuroses. American and British psychiatric statistics are in remarkable agreement about the high incidence (more than 50 per cent) of these anxiety syndromes (Fox and Schnapper, 1944-1945; McElroy, 1944-1945). Hysterical and depressive syndromes were second and third in frequency, but were outdistanced by the anxiety reactions by a wide margin. French statistics about psychiatric casualties during World War II tell a similar story, and so do the more fragmentary figures published by German military psychiatrists (J. E. Meyer, 1961). The relative incidence figures of these three syndromes did not change much during the Korean War.

In Chapter 1 we commented already on the fact that during World War I hysteria was the most frequent form of war neurosis and that in World War II the hysterical syndromes hardly made an appreciable dent in the psychiatric casualty lists. This seems to hold true for the American and British democracies as well as for totalitarian Nazi Germany. But there are two interesting exceptions: Japanese and Russian figures suggest that, in the fighting forces of these two countries, hysterical reactions were relatively frequent. Some Russian tabulations indicate incidence figures for hysterical reactions as high as 45 per cent of the total of war neuroses (Lustig, 1955). One is not sure how to interpret these figures. Some authors feel that the relinquishment of the dramatic, wildly gesticulating, hysterical body language reflects the increasing social isolation of contemporary man who feels that nobody listens so that all public gestures have become pointless. Others claim that the retreat from hysteria betokens an increasing numbness and lack of responsiveness in modern man who only reacts by means of dumb vegetative discharges. Still others proclaim that it betokens exactly the opposite, namely, a particularly deep emotional resonance (Strecker and Appel, 1945). It has been suggested that the higher incidence of hysterical syndromes among Russian and Japanese soldiers was a sign of greater militancy and martial fervor among these nations. In such a social climate, the grand hysterical gesture would be required in order to be allowed to opt out of the great collective war effort. Obviously, all such interpretations are highly speculative. But the observations which they attempt to explain underline once more the great importance of social factors in the shaping of individual and collective psychopathology.

*War stress and civilian populations* Modern war, mechanized and total, has muddled the distinction between combatants and noncombatants. During World War II, millions of civilians were exposed to



the nightmare of intense air attacks. On the eve of the war, psychiatrists had predicted that massive air raids on large cities would provoke panic and mass hysteria (Sargant, 1948). These expectations were not borne out. Very few civilians who lived through the inferno of large-scale bombing developed neurotic symptoms. Collective panic was practically unheard of.

Psychiatrists in the heavily bombed industrial centers of Great Britain unanimously reported a very low incidence of psychiatric casualties. One statistic may stand for many: Vernon (1941) reported that among 11,000 persons seen by the mobile ambulance units of the order of St. John in the air raid shelters of London, only 1.4 per cent displayed marked neurotic reactions, mostly anxious and depressive in nature. Similarly, German psychiatrists, and apparently also the Nazi authorities, were surprised by the emotional resilience of their civilians under strategic bombing. Reactions of apathy were observed, but these came rarely to the formal attention of psychiatrists and health authorities. We have only fragmentary observations (Okada *et al.*, 1953) on the psychic effects of the atomic bomb attacks on Hiroshima and Nagasaki. Here, too, the absence of collective panic reactions was remarkable. Among 200 patients examined by Okada and Shimazone in auxiliary hospitals of Hiroshima 40 days after the explosion, only 9 patients showed marked psychiatric or neurological symptoms. However, these figures are to be interpreted with caution. It may have been difficult in some cases to disentangle neurotic or psychiatric symptoms from those ascribed to the multiform "radiation sickness." At any rate, the almost total lack of any large-scale, visible psychiatric syndromes among civilian collectivities subjected to catastrophic disaster is one of the best established and most curious phenomena of World War II.

*Narcotherapy and the re-enactment of the trauma* The special etiology of traumatic neurosis makes it subject to special methods of therapeutic attack. In particular, treatment by means of hypno- and narcoanalysis has been notably successful in cases where the neurotic symptoms were of fairly recent origin and had been suddenly precipitated in a relatively normal personality by severe stress. The procedure in these cases is primarily to obtain a reintegration, a conscious reliving of a limited segment of psychic experience, namely, of the traumatic episode and the affects to which it gave rise. This type of procedure often leads to highly dramatic re-enactment scenes with tempestuous emotional outbursts. (It is this kind of cathartic fireworks which the average layman, who has read too many drama-

tized accounts of psychoanalysis, has come to expect from psychotherapy in general, even though in the treatment of the usual chronic neuroses such dramatics are fairly rare.)

Narcotherapy, which was developed during World War II for the treatment of traumatic neuroses and proved quite effective in this respect, also initially aroused high hopes as a method of attack against the more entrenched psychoneuroses. But these hopes were disappointed. A method of treatment where everything hinges on the reconstitution of a crucial trauma turned out to be ineffective with neurotic disorders where the decisive traumatizations had occurred in the remote past, and were likely, moreover, to have been distributed over a series of more or less telling experiences, none of which were crucial *per se*.

The procedure of narcotherapy is as follows: by means of sodium pentothal or a similar drug, the patient is put into a hypnosis-like sleep. In this condition, he is open to the suggestions of his therapist. After the narcosis has reached the desired depth, the therapist suggests that the patient is once again in a foxhole under fire, or aboard a burning plane, or in whatever traumatic situation that precipitated the neurosis. The suggested details are made as specific as the patient's record permits. Ordinarily, the somnambulistic condition of the patient brings it about that he readily goes along with this "game," and remembers, or, better, re-experiences portions of the traumatic episode in fearsomely life-like detail, in the course of which he recovers key incidents which had completely escaped his waking consciousness. Some patients even re-enact parts of the traumatic scene. Battle-scarred soldiers may get up from the couch where the drug was administered and

wander about the room looking for a slit trench, a lost friend, the Command Post, or whatever the action at hand calls for. Some live the scene through verbally and emotionally, without the production of much motor activity. They talk to unseen buddies, wince at unheard explosions, bury their heads under the pillow when the shells come close, and flatten themselves out on the bed, as if they were at the bottom of their foxhole. The terror exhibited in the moments of supreme danger, such as the imminent explosion of shells, the death of a friend before the patient's eyes, the absence of cover under a heavy dive-bombing attack, is electrifying to watch. The body becomes increasingly tense and rigid; the eyes widen and the pupils dilate, while the skin becomes covered with fine perspiration. The hands move about convulsively, seeking a weapon, or a friend to share the danger. The breathing becomes incredibly rapid and shallow. The intensity of the emotion sometimes becomes unbearable; and frequently at the height of the reaction, there is a collapse and the



patient falls back in bed and remains quiet for a few minutes, usually to resume the story at a more neutral point. Some patients return over and over again to one short, traumatic scene, living it through repeatedly, as if, like a needle traveling around a cracked record, they could not get past this point (Grinker and Spiegel, 1945, p. 80).

The purpose of this sort of therapy is to "introduce the ego to its recent past" (Grinker and Spiegel) and to enable it to assimilate the previously indigestible traumatic experience. The role of the therapist is that of a purveyor of comfort and reassurance, who encourages the ego once again to expose itself to the fear-producing situation and, at the same time, protects it against an unbearable intensification of anxiety. It frequently happens that large experiential fragments of the traumatic situation have been preserved in the consciousness of the patient, isolated from one another by various maneuvers of defense and thus robbed of their affective charge. The task of the therapist consists, then, in helping the patient to synthesize these fragments. Many patients seem to have been persuaded by their unconscious that they were literally annihilated in the traumatic situation, so that, at best, they now have only the reality and substantiality of an unexorcised ghost. Such patients must gradually be taught that their unconscious is mistaken; under the guidance of the therapist, they must be convinced that they survived the catastrophe.

Sometimes noticeable improvement occurs without formal therapy, as a result of spontaneous attempts at self-cure which manifest themselves most clearly in the dream life of the patient. One of the most constant symptoms of war neuroses are recurring, nightmarish "battle dreams," which repeat, with dramatic authenticity, impressive fragments of the traumatic incidents. These dreams can be interpreted as symptoms of the underlying anxiety, but also as attempts to come to terms with the traumatic experience. Indeed, it sometimes happens that a series of more or less stereotyped and fragmented nightmares is climaxed by a decisive dream which recreates with hallucinatory intensity the original trauma, after which the patient awakens limp and much improved. More frequently, however, the opposite trend is observed. Nightmares get more disguised, then rarer, then go away. In either case, the "dream work" expresses the spontaneous attempts at self-cure.

Observations made by military psychiatrists during World War II suggested that the prognosis for quick recovery was best when the patients could be treated right behind the battle line, and as soon as possible after the traumatic experience. These observations were con-



firmed during the campaign in Korea. Glass (1951, 1953, 1955), reporting on the psychiatric aspects of the Korean War, emphasized that psychotherapy for combat reactions of recent origin ought not to be deeply probing and analytical in nature, but rather should soothe and comfort the patient, helping him to bury the recent past.

*Prognostic outlook* Prognosis depends partly on the speed with which psychiatric first aid is given, but more importantly on the solidity of the premorbid personality. During the Korean War, 65 per cent of American psychiatric casualties could be restored to full combat duty, 5 per cent had to be returned to the United States. A follow-up study by Brill and Beebe (1955) on 995 war neurotics indicated that five years after the termination of the war, 45 per cent of the sample were free from symptoms, whereas 8 per cent were still suffering from symptoms classified as severe. Among a number of chronic war neuroses of World War I, Kardiner reported a deterioration in the direction of psychotic-like states. In general, it can be said that the prognosis for the more chronic forms of neurosis developing out of combat reactions is about the same as for other forms of chronic neurosis, that, in fact, the clinical pictures are hardly distinguishable.

### *The Anxiety States*

Since we have already dealt at some length, in previous sections, with anxiety and its clinical manifestations, our presentation of anxiety neurosis<sup>3</sup> can be rather brief.

The chief symptom of anxiety neurosis is manifest, diffuse anxiety. Being not welded in a stable way to any particular object, such anxiety is called "free-floating." Its nature can be compared to that of a "free radical" in chemistry, in constant search of an object to which to attach itself. It is relatively rare that diffuse anxiety maintains itself as such for long periods of time. Sooner or later, it disowns an object upon which to fasten itself, and then evolves in the direction of phobic fear.

The nature of free-floating anxiety being what it is, we shall expect to find it often in periods of transition involving acute stress. And, indeed, anxiety reactions are frequent during such critical phases of the life cycle as puberty, the climacteric, and the interval between adolescence and manhood. Anxiety reactions are quite common among college students, whose lives are peculiarly transitional, com-

<sup>3</sup> The terms "anxiety states," "anxiety reaction," and "anxiety neurosis" are used interchangeably.

parable in many respects to the passage through a compression chamber before exposure to the social world at large. McArthur (1961) has described this condition of inchoate, anxiously agitated moods in young men of college age: "These young people have a private moving picture screen in their head that plays a continuous feature, but the projector is out of focus. Their problem is to avoid always watching this disturbing private movie. They are therefore agitated, labile, distressed but unsure as to what distresses them. They try every sort of defense against this return of the repressed, with little effect" (In Blaine and McArthur, 1961, p. 68).

*A case of anxiety neurosis* A college freshman whose inner projector was decidedly out of focus presented himself at the Psychological Clinic of a West Coast university. He was an open-faced, nondescript looking young man who came on his own initiative. He was not sure what was bothering him, except that periodically he was gripped by "a funny feeling—as if all hell might break loose." He could not attach this feeling to anything concrete. He had gotten mediocre grades in two exams, which was disappointing, but hardly catastrophic. The only other "problem" he could think of was an itchy rash on his neck and hands, which made its appearance whenever he would "sweat over his studies" for long hours. A doctor had told him that it was probably nervousness.

He cannot remember exactly when his vague feelings of doom first started—perhaps half a year ago. He is not aware of anything important having happened around that time. But almost immediately following this disclaimer he mentions, a bit too casually, that his mother, a divorcee, had gotten remarried about seven months ago. She had been working for the State Department in Washington and had gotten "entangled with some aristocratic foreigner who finally proposed to her." Charles—as we shall call our patient—had lived with the mother up to that time, but shortly after the wedding had been "packed off" to California, ostensibly to get himself educated, but in reality—so he thought—to be out of the stepfather's way.

A curious incident had happened during the wedding party. His father, a college professor, who had remained on the best of terms with his ex-wife, had been invited, and he showed up with "a blonde of college age in tow, who was oozing sensuality out of every pore." This surprised Charles who had always

thought of his father as an abstracted ivory-tower type. His surprise increased when the father got rather high and indulged in demonstrative necking with the girl whom he had introduced as his research assistant. Charles, who judged this public display to be in poor taste, felt scornful towards the father—and envious. The morning after, he had awakened feeling gloomy and depressed, but had soon recovered from his dejection. By now, he felt resigned to the mother's remarriage, and he had decided that the father's doings with the research assistant were not his, Charles', business.

Asked if anything in his present life situation was bothering him, Charles hazarded: "I just do not get anything out of sexual experience with girls." He went on to say that he was attracted by pretty girls and dated a lot, but that every time he got to the stage of physical caresses he would "feel shook up and disappointed . . . as if there is nothing there." There was Sue, a girl whom he had dated regularly during the early weeks of the term. They mostly played bridge, and discussed modern poetry, but he had grown quite fond of her. Then suddenly, two weeks ago, she had dropped him. Charles had felt "next to nothing," and he allowed how this lack of reaction had slightly bothered him.

During the second interview, Charles mentioned that he had been plagued by an odd feeling of late—"as if an axe was going to come down." Also he had begun to experience insomnia. He had pretty much decided to quit school, head East, and find himself a job as a mailman. Ideally, he would have liked to "slink off to a South Sea island, eat coconuts, and write." The night before the interview, he had dreamed of being an artist. In the dream, there was at first a man alone in a room with a painting and a manuscript. Then a girl came into the room. She wanted to buy the painting but somehow knew that it was not for sale. The painting was of a drop of blood painted in red and black. The girl asked the man if he would sell the painting, but he did not answer. There was a manuscript on the table with the title *Blue Smoke*. The girl left. End of dream. Charles' only comments were that blue smoke reminded him of ozone with its acrid pungent odor and that the girl "looked like any girl—just a person, an average, normal girl." Was he hinting, the therapist wondered, that he had nothing to offer to a normal girl, except an acrid smell and a drop of blood?



This hunch was confirmed by the subsequent psychological tests which clearly reflected the picture of an agitated anxiety state. On the inkblot test, he perceived many mangled, mutilated, malformed human figures, looking "like animated vegetables." One card reminded him of "some barely human thing out of Science Fiction, with no neck and squat head, huge legs and shrivelled, diminutive arms . . . something of the sort that thalidomide would . . . [unfinished sentence]." He even managed to make out a castrated octopus whose tentacles had been removed "for some foul experiment."

The story-telling test (TAT) indicated that the marriage of the mother with an "aristocratic foreigner" had been a much more traumatic event than he had allowed himself to realize. One of his stories told of a "young American upstart" who is challenged to a duel and killed by the Old World Duke Valkanski. The reason for the duke's enmity was the young American's rashness in wooing "the princess" whose hand and fortune the older man was coveting for himself. The princess herself was described as rather broad-minded. She did not mind having two lovers at a time. So she had to be poisoned in the end.

Another story suggested that being dropped by a girl, after having vainly tried to communicate to her "the depth of one's limited vision," is a very painful blow. It is the more painful since it is read by the hero as confirming his lack of manliness, so painful, indeed, that its emotional reverberations need to be repressed. We understand now why Charles had to maintain, vis-à-vis himself and the therapist, that Sue's desertion had left him unmoved.

In fact, there had been three "desertions." The first, and probably most consequential one, was the mother's remarriage. The father's refusal to live up to the image of the sexless ivory-tower recluse was another desertion of sorts. Finally Sue's dropping him, presumably in favor of a more masculine rival, was one blow too many. It intensified his unconscious fears that he had nothing to offer to a girl but "an acrid smell and a drop of blood." He managed to repress the real object of his fear; what emerged was diffuse anxiety.

From a psychodynamic point of view, the eruption of diffuse, free anxiety means a breakdown of defenses, but only a partial one: while the painful affect of anxiety can no longer be warded off completely,

its breakthrough remains nevertheless circumscribed. The defenses work at least to the extent of veiling the real threat by covering it with the mantle of indistinctness. The assumption is that no matter how painful the anxiety attack, its painfulness and destructive potential would be considerably increased if the real, naked traumatic threat had to be faced. The result, presumably, would be panic.

As far as prognosis is concerned, the anxiety neuroses, in spite of their subjective unpleasantness, or perhaps because of it, are usually considered to be fairly benign; they tend to be "peripheral neuroses" (Schultz, 1955) which leave the core of the personality relatively intact. Among the various neuroses, they offer the most promising outlook for therapeutic intervention or spontaneous remission.

## *Phobias*

### THE VARIETIES OF PHOBIC FEARS

When neurotic anxiety coalesces with an implausible object we are in the presence of phobic fear. On closer inspection, it turns out that the implausible object (or the implausible situation) is a symbolic surrogate for the actually feared object or danger situation. Since the phobic object is not the real object meant by the phobic fear, the latter turns out to be inflexibly irrational. It is love's labor lost to demonstrate the absurdity of his fear to one afflicted with a phobia. In fact, the phobic person may interpret such an effort at enlightenment as an assaultive act since it threatens to force him into a confrontation with the actual basis of his anxiety.

The phobias offer a heyday to those enamored of taxonomic subdivisions and ponderous diagnostic neologisms. For a while, it was a favorite pastime among clinicians to catalog the phobias according to their content, which then served as the basis of a high-sounding Greek name. Since, however, a phobia can attach itself to practically any object, this kind of taxonomic endeavor has a tendency to proliferate without bounds.

Of greater practical relevance no doubt is the fact that certain kinds of phobias are more common than others. Among the most frequently encountered are those graced with the names of claustrophobia (fear of closed spaces) and agoraphobia (the fear of open spaces). Also stage fright, examination anxiety, and fear of those in authority often reach phobic proportions.

In many societies, certain nearly universal phobias can be observed; these frequently appear in the guise of widely held superstitions



which act as the nucleus of the subterranean collective anxiety. *Pavor nocturnus*, fear of the dark, is an almost universal phobia of childhood. One can detect the hooks on which phobias could be hung in most normal men and women—exaggerated fear of mice, insects, snakes, the water. The preferred content of individual and collective phobias is subject to historical fashions; the syphilophobia, for example, which was so prevalent in the twenties, can scarcely be found today—due in great part, of course, to technical advances in hygiene and treatment. On the other hand, a phobic fear of cancer is common today, and is found with special frequency in psychotic and pre-psychotic constellations. These last two examples show that phobic fear often attaches itself to genuinely harmful objects. In such cases, we consider the fear phobic when it cannot be justified in terms of objective findings, for example, when a fear of cancer persists despite repeated negative findings from thorough examinations.

#### THE LATENT MEANING OF PHOBIC OBJECTS

The manifest content of a phobia is usually linked associatively with the actual danger situation and at the same time remote enough from it to permit the anxiety to be held within tolerable bounds. The psychoanalysts speak of a *displacement* of fear from the original to the phobic object. In the transparent, simply structured phobias of childhood, it is as a rule easy to discover who is concealed behind inordinately feared objects, such as the Big Bad Wolf or the Wicked Witch (usually Papa or Mama!), and, furthermore, it is easy to trace out the associative pathways which led to the choice of the particular symbol used.

If, from a functional, teleological point of view, we ask what the phobic displacement does for the patient, the most evident answer lies in the way in which it diminishes his subjective suffering. In comparison to the torment of free-floating anxiety, the affect connected with phobic fears represents a lesser pain, a subjective amelioration. The essential point here is that the person afflicted with a phobia is not, like the anxiety neurotic, in thrall to a nameless peril which he can't identify, but has rather found a focus for his apprehensions and can therefore take such countermeasures as flight, avoidance, or psychic preparation for the encounter with the dreaded object or situation.

By the same token, however, the transition from anxiety neurosis to phobia, subjective amelioration though it may be, represents a worsening of the clinical situation. Because diffuse anxiety is not



bound up with any specific object, it does not necessarily lead to abandonment of objects and object relations; the phobia, in contrast, unavoidably brings with it a shrinkage in the surface of contact with reality for the person afflicted by it. Beyond this, many phobias show a fatal tendency to spread progressively, invading ever-new segments of reality. Thus a phobia can finally lead to an extremely circumscribed existence coupled with inability to work and general psychic invalidism.

It can—but it does not follow that it must. Many phobias come to rest at a particular point without further proliferation; others regress spontaneously, or even disappear entirely under favorable conditions, which is a regular occurrence in the case of childhood phobias. Brun (1951) takes the view that full-blown phobias most frequently appear in adolescence and not infrequently show a gradual diminution or extinction with maturity. He sees this as a proof for the psychoanalytic thesis that phobias are closely bound up with the sex life and its phases.

Just what is it that the phobic personality actually fears? According to psychoanalysis, phobic fear, like all neurotic anxiety, is fear of the id and its drives—fear that repressed impulses will break through. In this perspective, the apparently external threat or danger must be seen as in fact a situation characterized by temptation. What the person afflicted with a phobia is actually afraid of is the danger which is embodied in the fulfillment of deeply rooted, intensive, but unconscious wishes. This intimate association of a conscious fear with an unconscious wish which signalizes the phobic constellation is one of the more interesting discoveries of the depth probings of psychoanalysis which delights in the paradoxical dialectic of manifest content of consciousness and latent, or underlying, meanings thereof.

*A case history* An excellent example of these relationships is offered by Brun (1956) in the following case history:

I once analyzed a lady who, among many other phobias, suffered from an insuperable railway phobia which necessitated her being accompanied by a girl friend whenever she had to travel from her home town to the nearby city of Zurich. Once, when her girl friend was unable to come along, she took her two-year old child with her! In spite of everything she clung to the belief that her fear was caused by the real danger of becoming the victim of a railway accident. She was also afraid that her husband who was often away on business trips would suffer a railroad accident, and she always expected that one day he would be brought back dead to their home. . . . Analysis revealed that this woman had once, when she was still a young girl, met a charming young man during a night-time rail-

way trip and had been so captivated by him that she gave in to his insistence and upon arrival at his destination went with him to a hotel. Their love-making had been followed by a violent fear of pregnancy. She had completely repressed this experience; her irrational railway phobia which if duly translated was not so unjustified after all, had taken the place of this forgotten memory. There was a real danger that she might experience during one of her railroad trips a similar "traffic accident," namely an adulterous adventure, since she had come to realize that she did not love her husband and looked back nostalgically to that pleasant railroad acquaintance. The elucidation of this state of affairs made the phobia vanish and from then on the woman was able to make the trip to Zurich unaccompanied and without any fear (pp. 646-647).

This example clearly shows that the phobic fear often contains a realistic element—fear of "going off the tracks"—but in a distorted form, and overgrown with secondary ramifications.

As in Brun's case, many phobias of long standing can be made to disappear if one manages to bring to light the unconscious wish behind the fear and the tempting character of the phobic situation.

#### THE THERAPEUTIC TASK

In general, the prognosis for the psychotherapy of phobic neuroses is favorable, even when the phobias are long established. Phobics, like anxiety neurotics, are usually not burdened with excessively proliferating defenses so that therapy can come to grips relatively soon with the crucial neurotic material. The therapeutic task as such is clear: it involves bringing the repressed impulses into consciousness and removing the phobic displacement; in the case cited by us, it is to uncover the sexual temptation hiding behind the phobic fear of railway accidents.

It ought to be mentioned that phobic fears are not appropriate handles for moral muscle-building. It sometimes happens, inside and outside of therapy, that phobic patients are exhorted to face their fear squarely, to expose themselves to the dreaded situation—a feat of bravery usually quite beyond their means. Such attempts at heroics are not only futile, they are also unnecessary if the patient is in the hands of a competent therapist. The uncovering of the relevant connections in psychotherapy will greatly reduce the phobic anxiety after which the patient stands a much better chance to victoriously confront the dreaded situation. Nobody need fear that, by things thus being made easy, the patient will lose a golden opportunity for toughening his fiber. There will be, in the course of normal life, and *after* the reduction of phobic fears, always enough occasions for the display of moral fortitude.

# 4

## Psychoneuroses II: Hysterias and Obsessive-Compulsive Neuroses

This chapter deals with hysterical and obsessive-compulsive syndromes, which are distinguished from anxiety neurosis and the phobias in that open anxiety is no longer a primary symptom. With hysterics and obsessives, anxiety may emerge now and then, but much of the time it remains latent. It is screened by a proliferation of defenses and neurotic symptoms which run the whole gamut from gross hysterical paralyses to the most recondite obsessional thoughts.

### *Hysteria*

The neurotic conditions comprised under the label of hysteria are of particular historical interest in that they constituted the point of departure for the pioneering investigations of Charcot, Janet, Breuer, and Freud. The outlandish phenomena presented by hysterical patients forced clinical psychiatry to come to grips, however reluctantly, with theories propounding a psychological etiology of "neurological" diseases.

In order to understand the extreme resistance of many medical men against the psychogenic theses of Freud, it is necessary to know that nineteenth-century Western psychiatry was a branch of neurology with which it shared—as it did with general medicine—the one-sided, but axiomatic and unquestioned, belief in the (for its purposes) primary relevance of the *somatic* side of human beings. Its official motto was "Mental diseases are diseases of the brain." This myopic fascination with the soma was in



line with a larger cultural premise which attributed the greatest degree of reality to whatever is most tangible; and nothing is more tangible about man than that he is endowed with a body. It did not occur to medicine, in the heyday of the triumphant natural sciences, to call itself expressly "somatic." To do so would have meant to perpetrate the esthetic sin of tautology.

Some of the syndromes of hysteria were already described in classical Greek medicine which provided the diagnostic label and also intuited a connection between the disease and the vagaries of sexual life. Hippocrates held hysteria to be a women's disease and explained its etiology by a somatic thesis *sui generis*: He advanced the notion that the organs of generation of the woman, and especially her uterus (hystera = Greek for "womb"), if frustrated in their natural longing to conceive and bear children, begin to wander about disconsolately in the woman's abdomen, causing by those untoward peregrinations the various hysterical symptoms. The notion of hysteria being exclusively a woman's disease has maintained itself through many centuries till the recent past. Freud still caused a storm of indignation and mockery among his erudite Viennese colleagues when he dared to lecture to them about a case of male hysteria. But, as has often been the case in similar instances, this erroneous belief which tenaciously survived so many centuries, has now been partly rehabilitated as containing a kernel of truth. While it is generally recognized today that hysteria is no respecter of the male sex, medical statistics do document its greater affinity for women among whom it is several times as frequent as among men.

#### TWO SUBTYPES OF HYSTERIA: CONVERSION REACTIONS AND DISSOCIATED STATES

It has been said that an exhaustive description of the varieties of hysterical symptoms would read like a mail-order catalog, requiring each year a new edition. This is because hysteria can mimic an almost unlimited number of the diseases and disease symptoms known to man.

Present nosology usually distinguishes between two subtypes of hysteria: conversion hysteria and dissociated states. As *conversion hysteria*, we label those syndromes characterized mainly by *somatic* symptomatology. They include such conditions as hysterical paralysis of arms and legs, functional blindness and tunnel vision (restriction of the visual field), hysterical deafness, tremors, tics, seizures, anesthe-

sia (lack of sensation), analgesia (insensitivity to pain), and stigmatisations of the skin. Other conversion symptoms are hysterical aphonia (the patient is able to talk only in a whisper) and mutism (total loss of voice), astasia abasia (the patient is able to sit, but can hardly stand or walk), and camptocormia (a distortion of the spine which forces the person to remain in an odd, forward-bent posture). Less outlandish are hysterical vomiting, writer's cramp, and "globus hystericus" (lump in the throat). Almost any organ or part of the body can be affected by conversion hysteria. What all these symptoms have in common is that the disturbance is functional, that there is no demonstrable structural damage in the affected organ (except for such secondary damage as may arise from lack of use, for example, waste of muscle in a hysterical paralysis of long standing), and, consequently, that the dysfunction is, in principle, always reversible.

In the *dissociated states* (or dissociative reactions), repressed psychic complexes stage a sort of "coup d'état" and seize temporary control of the executive centers of personality. They then proceed to dictate the person's behavior, in a manner often much at odds with his traditional ways. But their victory tends to remain incomplete and provisional. Frequently while in ascendancy they fail to take full possession of consciousness which becomes partly extinguished or clouded. And as a rule, the old personality will sooner or later reassert itself and relegate the usurping complex to its former state of subjugation.

This dissociated state of affairs is most pronounced in *multiple personality* in which two or more separate and markedly different personalities dwell in the same person and manifest themselves in alternation. The parasitic personalities can be quite complete, developing histories and memory systems of their own. The important thing is that the various personalities do not know of each other. They are total strangers, living in the same house, not even aware that the other exists. In the case of double personality, personality 2 is usually the negative mirror-image of personality 1. If personality 1 is kind, decorous, taciturn, personality 2 may be cruel, shameless, loquacious. The two personalities may follow different occupations: number 1 may be a policeman and number 2 a burglar. In the famous Beauchamp case, described by Morton Prince, five distinct personalities were identified.

In *somnambulism* (sleepwalking), the hysterical split is less radical. The sleepwalker gets up from bed without waking, but with his eyes



open or half open, performs various acts, which sometimes unmistakably have the character of wish fulfillments (for example, adorning his head with a child's golden paper crown), then returns to bed, and sleeps the rest of the night. The person is not aware of his sleepwalking, neither while he is engaged in it nor afterward.

In hysterical *fugue*, the sleepwalking, so to speak, carries over into waking life. The person may leave his home for work one morning, as he has done many times before, he may feel slightly absent-minded, take the wrong turn at a certain corner—and then all of a sudden come to, as if awakening out of a trance, in a strange town, hundreds of miles from his home, having no idea how he got there, perhaps not even aware that he is in a new environment or that he ever had a different home. Most likely, he will have complete *amnesia* for his past; he will have forgotten his name, his former address, his family ties—his whole former identity. His memory of the first days in the new environment may be extremely hazy. Gradually a new identity may emerge—he may assume a new name and settle in a new pattern of life which may be strikingly different from his former one. Upon recovery, he will take repossession of his former past, but now will repress everything connected with his escapade. In such hysterical flights, the motivational pattern is often almost embarrassingly transparent. The patient wants to escape from a burdensome situation, his conscience calls him a deserter and a coward, and so, one day, he wanders off “without knowing what he is doing.”

The dissociated states have attracted, in recent decades, much less clinical interest than conversion reactions. This may be in part because clinical psychiatry has become fascinated with the enigma of “conversion” (the apparent transformation of psychic impulses into physical symptoms); in part, this relative neglect may simply be due to the fact that dissociated states occur infrequently even though, as a consequence of their dramatic symptomatology, they are a favorite topic for journalists and scenario writers.

Common to both conversion hysteria and dissociated states is the splitting off of large tracts of the personality which are relegated to the unconscious in the form of relatively well-organized and coherent “miniature personalities.” These entities then proceed to manifest themselves in tangible ways. It may be mentioned, in this connection, that the boundary line between the two kinds of hysteria is sometimes blurred, that a temporary clouding of consciousness, a primary symptom of dissociated states, can also be observed in many cases of conversion hysteria.



## THE PARTIAL VANISHING (DECREASE IN INCIDENCE) OF HYSTERIA

We have already mentioned that the relative incidence of hysteria has enormously decreased since the days of Charcot and Freud. We have also speculated about the possible reasons for this decrease. One suggestion was that the increasing emotional isolation of the individual and the heightened chilliness of the general social atmosphere may have been major factors in the eclipse of hysteria. We are inclined to think of hysteria as a disease which gesticulates, which directs a dramatic appeal to others, and which hence presupposes an audience ready to pay some attention. If such an audience is lacking, hysteria loses its social *raison d'être*.

Let us push this inquiry about the partial vanishing of hysteria one step further. It has sometimes been argued that the Freudian discoveries which decoded the symptom language of hysteria may also have contributed to the extinction of the disease. One could almost say that Freud discredited hysteria as a means of signaling distress, at least as far as the more educated classes are concerned. Once it became widely known that hysterical manifestations were not to be taken at face value, it became much more difficult to be a bona fide hysteric, which means that it became difficult to be hysterical at all.

If this argument were valid, it would imply a rather ironical corollary, namely, that the Freudian elucidation of the meaning of hysteria, which was a major scientific feat, may have forced many patients who formerly would have developed florid hysterical symptoms to manufacture syndromes of a much more obscure and intractable nature. At any rate, the psychiatric literature suggests that the decrease in the relative incidence of hysteria has been more than compensated for by an increase in character neuroses, obsessional neuroses, psychosomatic disorders, and other syndromes which are often extremely difficult to treat.

Reflections of this kind make one realize the ambiguities of medical progress. They also raise perplexing questions: in a certain perspective, mental—and, perhaps, much somatic—pathology may be seen as indicating that something is amiss in the patient's total life situation. In this view, a symptom or an illness is a channel of expression for an underlying malaise. If by therapeutic procedures of a quasi-magical efficacy one helps the patient to get rid of his symptom—without solving at the same time the underlying life problem—it may actually turn out that,

from a long-range point of view, one has done him a disservice by depriving him of a needed means of communication. The result may well be that his basic "un-ease" will then manifest itself in a more devious, insidious form—a development which one can observe in certain case histories. Similarly, we may well be rendering society a questionable service by eradicating too completely certain relatively benign forms of disease (anxiety states, hysteria, headaches, the common cold, minor infections), if in so doing we increase the incidence of more malignant ones. These reflections are of obvious relevance to our strategy of dealing with—to name only two examples—tranquilizers and the so-called miracle drugs.

Not only the over-all incidence of hysteria has decreased in the last 40 years or so; one also notices shifts in the relative importance and frequency of particular hysterical symptoms. For instance, the once frequent "great hysterical attacks," mimicking in most particulars the symptomatology of the "Grand Mal" epileptic fit, have by now vanished to an extent that most of the present generation of clinicians know about them only from description in textbooks. Whereas hysterical paralysis and hysterical tremors were the most frequently observed hysterical reactions among the soldiers of World War I, the reports on World War II stress the prominence, among conversion symptoms, of hysterical fainting (particularly frequent among members of the Air Force). The most frequently encountered conversion symptom in present clinical practice is hysterical pain, a symptom not even described as such in the pioneering accounts of Charcot and Janet (Ziegler *et al.*, 1960; Purtell *et al.*, 1951).

*A case of hysteria in a young woman* Before discussing the etiology and the psychological meaning of hysteria, it may be useful to present an illustrative case.

Mary, as we shall call our patient, was a young, white Protestant woman in her early twenties, tall, dignified, handsome-looking. At the time of her first consultation, she was working as a free-lance illustrator for a number of magazines. She gave freely of her time, without being actively militant, to civil rights causes.

She came to see the therapist because she had gone through three abortive romances which she described as curiously vapid. The first two young men had reminded her of "unbaked gingerbread men"—colorless and pliable. The third was a Jewish boy named Jerry, slightly older than her, whom she had found "somewhat too pushy and aggressive," but who held a strange and, as she believed, unhealthy fascination for her. She described Jerry as affecting the role of a closet cynic. Their relationship,



which was anyway on the point of petering out, had come to an end recently when Jerry moved away to another town. To none of these three men, had she granted anything more physical than an occasional kiss. The sterility of these affairs made her wonder whether there might be something wrong with her.

The therapist was impressed by a certain vagueness in the talk of the young woman, as well as by the contrast between her air of graceful femininity and her obvious emotional immaturity. The feeling one got was that of a child dwelling in a mature woman's body. In order to gain a clearer diagnostic picture, the therapist suggested psychological tests.

Before the test results were reported, the therapist received a phone call from Mary's roommate who asked that her call remain confidential and then proceeded to relate the following incident which had taken place the previous evening, the details of which she had pieced together from Mary's account:

It appeared that Mary, who had been working very hard on some sketches to beat a deadline, had been visiting a girl friend of hers late at night when all of a sudden she felt very tired and dizzy. She remembered asking the friend for a second cup of coffee, and then suddenly seeing flashing lights in front of her, black and white—"sort of like asterisks." Mary felt increasingly abstracted while holding on to her cup of tepid coffee. When she tried to fixate the cup her eyes went cross-eyed. All the objects in the room seemed to slide off to the left, with an odd undulating motion. At this point she lost consciousness and came to on the floor. The first thing she remembered was her friend forcing her to lie down on the bed. The friend called a doctor who examined Mary and sent her home. According to the friend's report, Mary had wandered about the kitchen and the bathroom in a daze, apparently not knowing where she was. Mary did not know that she had had a convulsion until she was told about it by the doctor.

During the next therapy session, which took place two days later, Mary, rather casually, and without seeming much concerned about it, mentioned the "attack." It was the first of this sort she had ever experienced. The therapist insisted that she arrange to see a neurologist in order to rule out an epileptic fit. The neurological findings subsequently turned out to be negative, thus confirming the therapist's impression that the fainting episode had been a hysterical attack.

Mary at first could not think of anything arresting that had happened to her in the days immediately preceding the attack. But the therapist's prodding questions brought out two important sets of facts.

For one, Mary's older sister had gotten married very recently. Mary had not attended the wedding, but in the nights preceding the hysterical episode had repeatedly dreamt about the ceremony, seeing herself in the role of the bridesmaid. In one dream she had witnessed a double wedding. She described these dreams as mostly confused and unpleasant.

The second set of facts had to do with her former boy friend Jerry who had shown up in town on a business visit and had made a date with her. They had gone to dinner together, during which Jerry had had a few drinks, and then had gone for a ride. Jerry drove into the open country-



side, stopped the car, "threw himself" upon her, embraced her, and began to unzip her dress. Mary, scared to death by this "attack out of a blue sky," felt numb all over, but she resisted strenuously and managed to repulse her attacker. She noticed that she was shaking all over. The worst of it was that now Jerry began to berate her mercilessly, accusing her that her civil-rights crusading was just a sham, and that she refused to make love to him because he was Jewish. Mary felt tortured and crushed, unable to retort anything. She felt unjustly accused, yet vaguely guilty. Finally Jerry took her home. She got undressed, took two sleeping pills, and fell into a deep, dreamless sleep. The next morning she had "almost forgotten" the ugly incident and hardly ever thought of it since. All this had taken place a week before the hysterical attack. She appeared calm and collected while reporting the incident, with only a faint tremor of the voice betraying the underlying emotion.

The psychological test report described her case as one of "galloping innocence." The tester noted that, in the best hysterical manner, Mary had managed to repress almost everything pertaining to sex. (In a therapy hour it had transpired that this college-educated young woman had only vague, imprecise notions about the physical configuration of boys.) For some reason, this repressed side of herself was now beginning to return with a vengeance. Her inkblot test production consisted of an odd mixture of innocent "butterfly" responses and thinly veiled sexual content. She appeared to be blissfully unaware of the crude lasciviousness of her test responses.

In the story-telling test, the tester picked out a theme which seemed the more curious in the light of her subsequent symptomatology. This story dealt with a haunted garret in which a light switch kept going on and off by itself and which also was the locale of other untoward happenings. The tester raised the question whether this story did not hint at something being amiss in the "upper story," the intellectual sphere, of this girl.

The test report concluded: "This girl is estranged both from the biological-sexual sphere of life, and from the rarified atmosphere of the intellect, into which she had tried to clamber in her frantic efforts to deny what she sees as the dark side of herself. This double estrangement leaves her in a precarious position. She now dreams of a new escape. She wants to commune with nature, with beauty, leading a 'sort of Emersonian existence'. But however much she may try to feast on 'lonely beauty', her womanhood—no matter how undeveloped—has been aroused too much for her to be stilled by purely esthetic nourishment."

#### THE PSYCHOLOGICAL MEANING OF HYSTERIA

According to Freud's classical formula, hysterics "suffer from reminiscences." They are characterized by particularly massive repressions and memory gaps. In the case of our patient Mary, she had "forgotten" the traumatic incident of Jerry's assault the next morning. It is true that she was able to remember it without difficulty in the

therapeutic hour. But a crucial element was missing: the strong emotions, the fear, rage, and indignation, which the traumatic insult must have aroused. During the episode itself, Mary felt mostly numb. Afterward, she swallowed two sleeping pills, and with them further anesthetized her reactions. The next morning she felt composed and serene. In therapy, she was able to talk with casual detachment about the events of that evening. Only a faint tremor of her voice, of which she was unaware, betrayed her. She had almost totally repressed the emotional component, the affective impact, of the traumatic scene. But a few days after its occurrence, she developed a hysterical symptom.

In a certain sense, we can say that the hysterical symptom is a label pasted over a particular memory gap. It has a substitutive relation to the suppressed material, and is tied to that material with associative bonds. The symptom can only maintain itself as long as the full memory (which includes the affective component) at this point is missing, and will go away when the traumatic event with its reverberations is made conscious. This formulation points out the goal, though not necessarily the method, of the therapeutic enterprise.

Of course, our patient Mary had repressed much more than the affective component of a recent traumatic event. According to the psychological tests, she had repressed quite radically the sexual side of her being, as happens frequently with hysterics. We are probably not amiss in suggesting that the recent insult which preceded symptom formation owed its traumatic virulence to the fact that it was a partial repetition of earlier, more thoroughly repressed traumatic scenes. It is moreover likely that the sister's recent marriage, with which Mary dealt mostly in her anxious dreams, stirred up her anesthetized sexuality. Jerry's rash aggression further rattled the already weakened defensive barriers. Thus she could not react to his advances as to a mere brutal attempt to overpower her; a secret complicity within her, something which wanted to respond positively, robbed her of her moral, if not her physical, force, and made her "numb."

Psychoanalysis has taught us to conceive of hysterical symptoms as symbolizations of psychic impulses. Hardly anybody who has been exposed to psychoanalytic ideas can help thinking of hysterical vomiting as the symbolic spitting out of disgusting experiences, or of a "globus hystericus" (lump in the throat) as a refusal to swallow an insult or humiliation. The present-day clinician is hardly aware any

more that in doing so he is interpreting what he observes: he directly *perceives* the hysterically lame person as somebody who refuses to move on. The particular symbolic meaning assigned to a given hysterical symptom may vary from clinician to clinician, but the tendency to see *some* symbolic meaning in such symptoms has become almost invariant. As is well known, psychoanalysts tend to translate hysterical symptoms into the language of sexuality; their interpretations impress the non-Freudian often as far-fetched. A Freudian, upon reading our patient Mary's case history, will be likely to think that her hysterical fainting was a direct translation of sexual fantasies which included swooning as part of the imagery about intercourse. Of course, such a reading may be essentially right in the present case where the repression of sexual elements was so central and where the symbolic bond appears quite plausible. In other cases, one wonders. The psychoanalyst Fenichel (1945, p. 218) cites the case of a hysterical woman who suffered from sneezing spells. He interpreted her verbal productions as proof that for her the nose represented a male sex organ, and the hysterical sneezing symbolically substituted for sexual activity. Many present-day clinicians are less interested in looking for such sexual rebus puzzles. They are more apt to inquire what the patient is trying to communicate, to himself and to others, by means of his hysterical symptoms.

Now, the special interest of conversion hysteria consists in the fact that the symbols it uses are of a peculiar kind, that it translates psychic impulses not only into symbols—something which dreams and poetry also do—but that it transposes (“converts”) them into the language of an entirely different medium, the material medium of the human body. In hysteria, psychic impulses are said to “materialize” directly in the body. This way of looking at things brings clinical psychiatry face to face with the philosophical riddle of the body-mind problem. Freud spoke of the “sudden leap of psychic energy into physical symptoms” and was clear-sighted enough to recognize that he was only offering a descriptive formula behind which lay a mystery. Some latter-day clinicians, without solving the mystery, have tried to legislate it out of existence.

Stanley Cobb (1959) is fairly typical of a large body of opinion when he declares: “I believe that Freud's statement about the ‘mysterious leap from the mind into the body’ is today meaningless. There is no separation between psyche and soma; therefore there can be no leap. . . . I maintain that there is no leap



at all for one who believes that mind is not a supernatural phenomenon but is the active integration of the billions of nerve cells and hundreds of cell masses of the living brain. . . . Mind is a function of the brain just as contraction is a function of muscle. . . ." (p. 11). Cobb may be right in rejecting the Freudian formula of the "mysterious leap." But the concrete problem of the correlation between psychic and somatic phenomena is hardly solved if one proclaims that there is no separation between psyche and soma and that mind is simply a function of the brain. Such formulas are of little value unless they help us understand what happens precisely when the vanishing of a psychic impulse is closely followed by the appearance of a somatic symptom.

If one remains at the level of clinical observation, it appears that the body of the hysteric has a special facility for directly translating psychic impulses into the automatism of dramatic gestures. Where another person feels disgusted, the hysteric vomits. It is possible that in this immediate "materialization" of a psychic impulse by means of body language we see the survival, in the hysteric, of an archaic characteristic which once may have been the property of the entire human species but which fell by the wayside with the increasing differentiation of psychic life (Fenichel, 1945). In the same vein, Millar (1958) points out that the hysteric is not somebody who has learned more "control" over his automatic functions, as a fakir might, but that on the contrary he has never managed to detach himself from the tyranny of the automatisms of early life. He persists in operating at a preverbal level.

#### THE PROBLEM OF SYMPTOM CHOICE

If we raise the question of symptom choice (why does this person develop a paralysis rather than another hysterical symptom?), it becomes apparent that one major determinant of symptom choice is identification. The hysteric tends to take over the symptoms—which often were genuine organic symptoms—of significant others. It is well known that hysterics not infrequently "choose" as symptoms those characterizing the terminal disease of an ambivalently loved parent. The reader may remember the soldier of Chapter 3 whose lower arm became anesthetic after he discovered the mangled arm of his closest buddy. In the case of our hysterical patient Mary, it turned out that there was an admired and envied aunt by marriage,

a famous actress, lurking in the background, who had suffered from epileptic fits.

Many hysterics tend to take over the expressed or implied expectations of their physicians and to obligingly produce the appropriate symptoms. This phenomenon is called "iatrogenic shaping of symptoms." Ziegler *et al.* (1960) report the case of a woman who in the course of history-taking developed a deceptively accurate facsimile of the symptoms of myasthenia gravis (severe muscle weakness), an organic disease her doctor was apparently much interested in. "As the clinical syndrome emerged from these negotiations, the physician gained a fascinating patient, while the patient gained a fascinated physician." The same authors reported the cases of two medical secretaries working for neurologists, one of whom produced a hysterical facsimile of multiple sclerosis while the other one manufactured a naturalistic imitation of the symptomatology going with a certain form of brain damage.

Of course, identification is not the sole determiner of hysterical symptom choice. Clinicians believe that symptoms are "overdetermined," and the more conditions can be identified which appear to have a plausible bearing on the choice of symptoms, the more satisfied the clinician will be with his explanation. Other conditions affecting symptom choice, besides identification, often have to do with the patient's own medical history. A football player who has suffered repeated knee injuries is likely to choose his vulnerable knee as the locus of hysterical pain. Obviously, the suitability of a given symptom to symbolically express the crucial psychic conflict will further restrict symptom choice. In the individual case, one usually can isolate additional factors which favored the emergence of a particular kind of symptom. Since in this type of clinical analysis we usually rely on postdiction, rather than prediction, we need to be doubly cautious and critical vis-à-vis our formulations professing to account for the vagaries of symptom choice.

#### THE HYSTERICAL PERSONALITY

It has long been fashionable to talk of a hysterical personality which is supposed to be the modal personality type of the subjects developing hysterical symptoms. While the traits attributed to the hysterical personality vary, sometimes considerably, from author to author, a few core traits recur in most descriptions. The most frequently cited feature is that of a certain histrionic quality, a propensity to dramatize oneself which smacks of hamming and of the

"made-up." Whitehorn speaks, in this connection, of "emotional incontinence."

However, recent clinical studies have shown that the alleged correlation between the histrionic personality type and hysterical symptomatology is far from dependable. One such study found that only about 50 per cent of a group of patients suffering from hysterical symptoms actually displayed "hysterical" personality characteristics. Our patient Mary, whose case we studied, was singularly free from affectation. On the other hand, there are individuals who fit to perfection the description of the histrionic performer, whose every act is a "manifestation," and who nevertheless do not develop hysterical symptoms but other forms of neurotic symptomatology.

It is also well known that conversion reactions occur in clinical constellations which are dominated by depressive or schizophrenic features. Hence the occurrence of one hysterical symptom, or even of several, is not a sufficient warrant to make a diagnosis of hysteria. In fact, Reichard (1956) who re-examined the five patients described by Freud and Breuer in their original paper on hysteria came to the conclusion that two of the five had been misdiagnosed; they were schizophrenics rather than hysterics or, at any rate, would be nowadays diagnosed as such.

#### THE PROBLEM OF SIMULATION

The fact that many hysterical patients seem to "ham it up" has brought them time and again into the repute of being simulators. In pre-Freudian days, hysterics were often accused of manufacturing imaginary diseases which allowed them to exercise a diabolical tyranny over their families. But the problem of simulation did not come to rest, once and for all, with the Freudian formulations about the unconscious motivation of hysterical disorders; it was only reformulated in more up-to-date terms. Sometimes not even that. Some contemporary authors continue to accuse the hysteric of attempting to create an effect (Dicks, 1939), of plain malingering (Mayer-Gross *et al.*, 1954), of "playing possum" (Cobb, 1948). More sophisticated workers inquire to what extent semiconscious factors may reinforce and maintain the symptoms generated by unconscious conflict. Jaspers, using the language of the moralist, talks of the will to sickness, the "inadequate health conscience" of the hysteric.

It is undoubtedly true that many somatic symptoms of hysteria are such as can be made up, consciously mimicked. One can sometimes observe that something which appears to start out as simulation



slips over into hysteria no longer amenable to conscious control. This then raises the post-facto question of to what extent the original simulation may already have been driven by unconscious elements, and hence to have involved more than mere simulation. The motivational strands here are almost inextricably snarled.

Another circumstance which has repeatedly given rise to the suspicion of simulation is the fact that hysterical loss of function is selective: the hysterically deaf can suddenly hear and the hysterically mute talk when overriding interests are at stake.

The French phenomenologist Merleau-Ponty (1945) has given an excellent analysis of the problem of bad faith in hysteria. He uses a case of hysterical aphonia (loss of voice) as his take-off point:

To be aphonic does not mean to be silent; one is silent only if one can talk. . . . Aphonia is unquestionably not an organic paralysis . . . yet it is neither a willed nor contrived silence. . . . If the hysteric is a simulator, then in the first place vis-à-vis himself, so that it becomes impossible to draw a parallel between what he feels or thinks *really*, and what he expresses outside: pithiatism (hysteria) is a sickness of the cogito, it is consciousness grown ambivalent, and not a deliberate refusal to confess what one knows. In the same way, in the case under discussion, the young girl does not stop talking—she “loses” her voice as one loses a memory (pp. 188 ff.).

Hence, Merleau-Ponty suggests that the patient’s aphonia cannot be looked upon as the result of a voluntary decision, because such a decision presupposes an alternative, a possibility of choice. If we want to use the term “decision,” we’ll have to say that the aphonic’s loss of voice is decided upon, so to speak, in a psychic region beyond or below the domain where conscious decisions originate. In short, it is an unconscious decision, and the hysteric can be called a hypocrite at most in a metaphysical sense.

#### AN EXISTENTIAL-ANALYTIC DESCRIPTION OF A CASE OF HYSTERIA

The existential analyst Medard Boss (1963, 1961) has undertaken an interesting attempt to describe a case of hysteria without using the Freudian conceptual apparatus, without using notions such as “unconscious strivings” or “repression,” which most clinicians nowadays take for granted. The case he used is the following:

A nineteen-year-old girl passed by a flower nursery on her way to work every day. A young, handsome gardener who worked there seemed obviously interested in her; each time she passed he would look at her for a long time. The girl became excited whenever she was near him,

and would feel herself peculiarly attracted to him. This attraction bewildered her. One day she stumbled and fell on the street directly in front of the entrance to the nursery. From then on both her legs were paralyzed. Her doctor diagnosed a typical hysterical paralysis (Boss, 1963, p. 117).

A psychoanalytic interpretation of this case might say that the repeated encounter with the handsome gardener stirred up the *unconscious sexual impulses* of the girl, that a partial failure of *repression* occurred (she felt attracted by him), and symptom-formation (paralysis) ensued. Presumably, symptom-formation would entail a renewed repression ("forgetting" of the attraction for the gardener).

Now Boss looks at the matter in the following way: This girl had been brought up by very prudish parents who frowned upon the slightest sign of sensuality. Thus she grew up in the shadow of a prohibition which outlawed any inclination toward a young man. This "don't!" was so overpowering that it also laid claim to her bodily existence. (For instance, her physical development might have been delayed, she might have had menstrual troubles.) One day, this "don't!" realized itself ("carried itself out") in the bodily sphere as the paralysis of her legs. We do not need the psychoanalytic hypothesis that this symptom betokened a "return of the repressed" from a hypothetical unconscious.

According to Boss, we can simply state that this girl had been moving toward the gardener with her whole being. She had felt attracted to him in a peculiar way, and she did not "repress" into "the unconscious" the existence of the gardener nor his "image" and her fascination. On the contrary, all this was *oppressively* present for her, after as well as before symptom-formation. But on account of the overpowering parental "don't!" under whose constricting spell she was living, her whole relationship to the fascinating man was characterized by blind resistance. We call this resistance blind because the girl was too unfree and too constricted to grasp intellectually and articulate what she was doing. Of course, her desperate defensive struggle showed how powerful was the attraction emanating from the young man. Since she was unable to realize all this in the sphere of reflective thought, the struggle about the blocked relationship was carried out primarily in the bodily sphere: her legs became paralyzed. Nobody can prevent us from saying, if we are so inclined, in the psychoanalytic manner that the observable goings-on were accompanied by unconscious thoughts and impulses. The question is

whether we cannot get along, and get along better, without such a theoretical assumption.

In a way, Boss's formulation, which we have reproduced here in a very condensed form, is not implausible. Obviously, this formulation contains difficulties and riddles of its own. But the basic attempt is interesting. What Boss is trying to do is to describe a set of facts, which most clinicians perceive nowadays through Freudian glasses, in an alternate language which strives to adhere closer to the observed phenomena and to dispense with a cumbersome conceptual apparatus. Presumably the pay-off in such an enterprise would be that it would free our eyes and minds to see and understand new phenomena which at present are screened out by the thick lenses of theoretical preconceptions. Boss relates one such observation, namely, that the gardener remained oppressively present even after symptom-formation occurred. Looking at the same facts through psychoanalytic glasses, one would likely have "seen" that the girl *repressed* her thoughts or affects about the fateful young man.

#### "THE SPLENDID INDIFFERENCE" OF THE HYSTERIC

It remains to be added that from a clinical point of view hysteria is a rather efficient form of neurosis in the sense of being relatively successful in the binding of anxiety. In the hysteric, anxiety often vanishes from consciousness for long periods, and this leads to the curious incongruity between the disturbance or loss of function on the one hand, which is frequently very pronounced, as in cases of hysterical crippling of the extremities, and, on the other hand, the unconcern of the patient in the face of this loss. This incongruous *belle indifférence* of the hysteric was early described by Charcot as typical, and it constitutes a diagnostically valuable sign in cases where it is not clear whether one is in the presence of organic or functional disease.

In spite of the splendid indifference which hysterics manage to maintain during long stretches of their disease, they are not immune to anxiety, as some authors claim. Indeed, they experience it quite frequently; like other neurotics, they tend to become anxious when a repressed instinctual impulse seems to be on the point of breaking through the defensive barriers, be it as a consequence of therapeutic intervention or of spontaneous developments.



## TREATMENT AND PROGNOSIS

Psychoanalysis and allied forms of psychotherapy are, in the author's opinion, still the treatment of choice for hysteria even though some workers are disappointed with the treatment results of classical psychoanalysis (Millar, 1958). Others favor conditioning techniques based on learning theory (Eysenck, 1960).

Very dramatic hysterical symptoms, especially conversion symptoms, can sometimes be made to disappear after a few hours of psychotherapy which bring to light the relevant unconscious material. This is the more likely to happen if the symptoms are of relatively recent standing. If, however, the disorder has persisted over a number of years, without being treated or, what is almost worse, being treated as a pure organic disease, the therapeutic task can take on herculean dimensions.

With hysterical disorders, still more than with other neurotic syndromes, removal of symptoms by itself is not a sufficient criterion of cure. Hysterical symptoms show a disconcerting propensity to "wander" or to recur after longer or shorter intervals of remission. Hence before talking of cure, the psychodynamically oriented therapist will want to be reasonably sure that he has brought about personality changes which will make the individual less vulnerable and decrease the likelihood of relapses (Malan, 1959). With the present state of our knowledge, it seems requisite to be very conservative and to talk of cure only if a remission has been maintained over a number of years.

The author is not aware of any large-scale statistical studies investigating the percentage of cures in conversion hysterics treated by means of intensive psychotherapy. We do have a number of follow-up studies of hysterical patients who received little or no psychotherapy. The prognosis for these cases appears to be unfavorable. Guze and Perley (1963) reporting a 6- to 8-year follow-up of 25 hysterical patients found three possible cases (of which at least one case was doubtful) of significant spontaneous improvement. It is true that the authors defined hysteria in such a way that their sample was likely to include a disproportionately large number of severe cases. A sample drawn under less restrictive conditions would yield somewhat more favorable remission figures, as common sense and some incidental remarks of the above-cited authors suggest.

A particular difficulty in the case of conversion hysterics is that

they have a vested interest in clinging to organic explanations for their disease. Hence they are less likely to find the way to a psychotherapist than those suffering from other forms of psychoneurosis.

### *Obsessive-Compulsive Neurosis (Obsessional Neurosis)*

#### SYMPTOMATOLOGY: OBSESSIVE THOUGHTS AND COMPULSIVE RITUALS

Whereas in conversion hysteria the somatic sphere is a major locus of disorder, the symptomatology of obsessive-compulsive neurosis mainly involves the *psychic* realm. Obsessive-compulsive disorders are characterized by an extensive loss of the feeling of psychic freedom—the person under their sway feels as if he were possessed by insistently recurring thoughts, which he experiences as absurd or painful, or he may feel compelled to repeat endlessly the same, excruciatingly senseless, ritualistic actions. The sufferer appears to be under the spell of an infinitely powerful and arbitrary authority which he cannot localize but against whom rebellion is futile—as much so as the phobic's revolt against the taboos and prohibitions which circumscribe him.

We designate as *obsessive* those conditions in which the primary disturbance is in the sphere of thought, the characteristic feature being the insistent intrusion of haunting, irrational ideas. When the salient symptoms lie in the realm of manifest behavior and consist mainly of stereotyped, repetitious actions, we talk of *compulsions*. Since both types of symptoms frequently occur together or in succession and since the underlying psychological patterns are similar, they are subsumed under the common label of obsessive-compulsive neurosis. Sometimes the less cumbersome terms “*obsessional neurosis*” and “*compulsive neurosis*” are used as generic terms encompassing both subtypes, a usage of which the author will avail himself now and then.

Apparently, obsessions can crystallize around almost any thought or ideational content. Sometimes, it is only a fragment of a sentence, an abstruse conglomerate of words or syllables, a line of a poem, or a few measures of a melody, which take possession of a patient's mind and cannot be evicted. One such patient reported that he was haunted by the words “*ra-ra-ra, the bra,*” for hours at a time, whereas another one found the repetitious formula “*over the hills and into the woods, over the hills and into the woods*” (and so on) stuck like an unmovable shell splinter in his brain. Neither of the two was able to ascribe the slightest meaning to the obsessively recurring words. Frequently, the

obsessive thought is coherent as such, but appears to the patient as alien and psychologically absurd—and the more compelling, the more absurd. Thus a woman may be tortured by the thought that she will go insane and then, in her insanity, kill the husband whom she cherishes. It is quite typical for obsessive thoughts to take this particular form, namely, that some fatal accident is going to befall a loved one, either through the patient's doings or through the blind machinations of destiny. The reader may remember the phobic woman of a previous chapter who could not rid herself of the thought that her husband was going to die in a railway accident. (Phobias and obsessions frequently go together.) One encounters quite a few patients who are haunted by the obsessive idea of having done irreparable harm to themselves or others. One such patient kept thinking, in the face of contrary evidence, that, by some childish masturbatory acts, he had damaged his sexual organs beyond repair. Other patients, who are often very religious, are possessed by thoughts of a blasphemous character. A theological student was compelled to think incessantly about the "unforgivable sin," which he felt doomed to commit some day. The unforgivable sin consisted in getting up in church during the sermon and shouting: "God, too, has to make wee-wee!" Like many obsessives, this patient feared that at some future date the impulse reflected in the obsessive thought might become irresistible. Such fears are usually groundless. Hardly ever does the obsessive lose control over his impulses, especially those that are grossly dangerous or offensive.

Another major obsessive symptom is morbid doubt and rumination. The patient keeps turning over in his mind, endlessly, real or imaginary problems of greater or lesser import. He is unable to come to a conclusion because he sees 20 different facets of a problem. The most simple decision dissolves in unfathomable complexity. He may ruminate about all-embracing cosmological and metaphysical problems, speculating about the origins of Being and the existence of other minds; he may also be preoccupied with less portentous riddles, wondering why a chair has four legs or why the moon is round. But always his thinking, as long as it is stuck in these obsessive grooves, is sterile and formalistic, peculiarly void of empirical content. Pierre Janet, struck by the arid and finicky pseudo-logic of his obsessives, used to refer to them as "execrable metaphysicians."

In most cases of obsessional neurosis, obsessive thoughts are followed sooner or later by compulsive acts. However, in contradistinction to obsessive thoughts, compulsive acts are usually singu-



larly inoffensive. Many such acts, quite unmistakably, impress one as being of an expiatory nature. Thus handwashing compulsions and similar cleansing rituals look even to the superficial observer like acts of propitiation for real or fancied offenses.

Many compulsions consist simply of the endless, stereotyped repetition of the same simple act; the patient may have to recite a certain prayer 20 times in a row or to open and close an electric light switch 50 times in succession before he can go on to something else. In other cases, a whole string of obsessive acts is elaborated into an intricately complex and drawn-out ritual which must be performed with deadly accuracy. A patient may have to go through a lengthy sequence of deep bows and various other calisthenic exertions, facing successively in the four directions of the compass, before he is allowed to cross the threshold of his bathroom. A compulsive college student had to assemble in a mountainous, geometrically neat pile all the books and monographs having a possible bearing on his assigned topic, then rearrange the books in a flat, mosaic-like pattern, then sharpen as many pencils as he had books, and finally eat two green apples before he could begin to deal with his academic task.

An unusually impressive description of a ritual-haunted compulsive patient has been given by von Gebattel (1958). After describing a number of obsessions and compulsions which, at various times, almost totally devoured the patient's life, von Gebattel goes on as follows:

In general, compulsions rule him in every performance. They begin at once with getting up in the morning. This must proceed according to a ritual that has been laid down exactly. He divides each action, each performance, into the very tiniest single movements. Each movement must be carried out exactly, and to each he must attend carefully. Everything is ordered and laid out this way—getting up, washing, drying, getting dressed: first this movement, then that one. . . . Often he must stand with his arms upraised, clutching his sponge, before he can go further. Then again he must remain standing and think everything through once more, especially if he feels there is something he did not do right, or if he was "lost in thought" (i.e., was not attending closely to his task). This recapitulation appears especially after some disturbance or omission in the completion of his ceremonial. He is often tortured by the impression that what he must do has not been done right, or not precisely enough or not consistently enough, and for this reason he is actually never "well washed" or neatly clothed. He requires many hours for his toilet, never really gets through, and arrives late for everything. And for that reason he has a "guilty conscience." This compulsion for order rules everything, even the way he eats or goes through a door; in the latter act he must never come in contact with anything. If he touches something, he becomes dirty. If his father, in visiting the hospital, hangs his coat over his

bathrobe, the coat is soiled with urine and he must take care not to hang his coat next to his father's in the closet at home, otherwise he cannot put it on again. By contact, dirt can be spread over innumerable objects (pp. 173-174).

Some of the stereotyped, puppet-like practices of such compulsive patients look like caricatures of a time-motion study. In other respects, they remind one of the elaborate magic ritual of a necromancer. Closer study shows that the obsessional patient inhabits, indeed, a magical world and that a major function of his ritual is to ward off the demonic powers which lurk everywhere.

#### COMPARISON WITH HYSTERIA

Because obsessional neurosis is in important respects the polar antithesis of hysteria, a comparison of the two syndromes may prove enlightening. It is noteworthy, for instance, that the amnesias, the obtrusive gaps in memory characteristic of hysterics, are usually not to be found with compulsives.<sup>1</sup> The differing defensive structures in the two forms of neurosis have been illustrated by an analogy drawn from Homer. The hysteric has been compared with the companions of Ulysses, who stopped their ears in order not to hear the fatal song of the Sirens, and the compulsive with Ulysses himself, who did indeed listen but by lashing himself to the mast made sure that he would not respond. The compulsive neurotic is often conscious of objectionable impulses which the hysteric would repress, but the compulsive's awareness of such impulses is associated with a lessening of their affective energy and a blocking of their expression. The impulses of the hysterical patient can at least find partial release on the miniature stage of his symptomatic play-acting; those of the compulsive neurotic are notably more bottled up. In contrast to the torrid mental climate of the hysteric, the inner life of the compulsive is cool and lacking in affect. Experiences that touch him are raised wholly into the cold stratosphere of his cerebrality and thus robbed of their emotional impact. "The hysteric 'acts' and 'feels' while the compulsive 'thinks'" (Nunberg). But it is indeed a thinking in quotation marks, an abuse of rationality pointing to a hypertrophy of the intellectual organ.

The impulses of the obsessive-compulsive are characterized not only by their intellectualization, but also by the fact that they seem alien to him, appearing as "visitants from another world" (Freud).

<sup>1</sup> In this section, and the following ones, we use "compulsive" as shorthand for "obsessive-compulsive."

He experiences them, to be sure, but not as his own; they seem to issue from an ego-alien authority in the form of commands. It is this circumstance which gives them their fascinating and uncanny insistence. They are at the same time strange and familiar, and the neurotically constricted personality is capable neither of repressing them completely nor of resolutely accepting them. The compulsive neurotic finds himself in the paradoxical situation of being forced to think and do what he actually wants to think and do. He experiences his most intimate wishes—more or less distorted—as impositions from without.

#### THE WORLD OF THE COMPULSIVE

It is a well-established clinical fact that many compulsives are inordinately fascinated, consciously or unconsciously, by the realm of dirt, decay, pollution, and excrement and by the moldy, putrid aspects of death. Their existential world tends to be characterized by disgust and ugliness, frequently in the sense-modality of smell (nauseating odors). Much of their elaborate ritual can be easily understood as an attempt to ward off the sphere of the unclean with the aid of rites of purification (for example, handwashing compulsions).

In the waking life of many compulsives, filth, decay, and excrement are tabooed topics. They may hold their breath and actually get sick in their stomachs when confronted by a pile of manure; they sometimes can hardly bring themselves to pronounce the words which directly refer to the realm of decay and have to fall back upon extraordinarily sterilized circumlocutions. But in their dream-life, filth and pollution may be oppressively present; they keep dreaming of toilets and filthy bathrooms, of mounds of dirt and evil stench, and sometimes even of literally suffocating in filth and excrement. Many compulsives are mortified by the natural functions of the body, by what they feel to be the humiliating servitudes of the flesh. They endow filth with an active power of expansion and contagion. Particularly vulnerable and easily contaminated is the area of sexuality, which they tend to reduce to an area of dirty, excremental happenings.

Another salient feature of the compulsive's world is that it is a hostile and resistant world, carrying the imprint of blind, intractable sullenness. It has been often noted that compulsiveness goes with a peculiar kind of devious aggressiveness, with obstinate passive defiance of real or fancied authorities, with the transformation of life into an interminable battle against omnipresent, never decisively defeated enemies.



Psychoanalysis condenses these two major aspects of the compulsive world—decay and aggression—in its formula about the *anal-sadistic* orientation of the compulsive. It attempts to trace the genesis of obsessional neurosis to the anal stage of psychosexual development, during which the infant is said to be preoccupied with pleasurable feelings centering around the anus and the process of defecation. This stage tends to coincide roughly, in our society, with the attempts to institute toilet training, which may become a major battleground in the infant's conflict with parental authority. Thus the themes of anal-ity and of aggressive self-assertion become linked. The compulsive is seen by psychoanalysis as somebody who, not having come to terms with these two spheres, partly regresses, under stress, to the stage of "anal sadism." One possible reason for this regression is that his infantile interest in excrement and bowel function had been too early and too forcibly suppressed by those in charge of him, the ensuing wrath and hate against his oppressors having also been subjugated by the same regime.<sup>2</sup>

Of course, as with every neurosis, unresolved *sexual* (Oedipal) conflicts are also postulated to play a major role in the genesis of obsessional syndromes. One could say that the unresolved Oedipal conflicts are the *general* pathogenic factor, and anal-aggressive conflicts, the *specific* one, in the psychic etiology of obsessive-compulsive neurosis.

#### OBSESSIONAL DEFENSES

In the psychoanalytic view, it is primarily these suppressed aggressive and anal impulses which the compulsive neurotic tries to keep in check with his overgrown defensive apparatus. In these efforts he makes use not only of the previously described technique of *intellectualization*, but also of the related tactics of *isolation*. This is a process whereby an important experience or fragment of experience is lifted out of its total context, detached from its associative bonds, and so robbed of its emotional impact. Crucial elements of the traumatic experience are retained in consciousness, but kept anxiously at a distance from other elements; what is repressed is the consciousness of their relationship to one another. The already mentioned expiatory rituals are seen as symptomatic of still another defense, *undoing*. A patient who had "polluted" himself by "dirty" thoughts and mastur-

<sup>2</sup> While, for the Western child, the area of bowel control is the favorite battleground in the conflict with parental authority, it is by no means the only one. Other areas, such as eating and going to sleep, can also occupy the center of the drama.

bation attempted to cancel ("undo") his offense by reciting 150 times the prayer of angelic salutation.

In regard to the intellectuality which the compulsive neurotic misuses for defensive purposes, his belief in the "omnipotence of thought" is characteristic. This is the magical wish and fear, rooted in a childish megalomania, that he can produce tangible changes in the world by thinking alone, without recourse to actual physical operations. Thus, he may come to believe that he has caused the death of a relative by a mere wish for that event, which was based on an ambivalent love-hate relationship with the deceased.

#### THE CASE OF ARMAND D.

In contrast to the relatively simple and transparent structure of many hysterias, that of most obsessional neuroses is incredibly complex and tangled. If the following illustrative case strikes the reader as overly convoluted, he ought to be told that the case history has been, in actuality, drastically pruned for didactic reasons. If the author manages nevertheless to convey a feel of the labyrinthine intricacy of the psychological texture of obsessional syndromes, so much the better.

*Presenting picture* Armand D. was a college student in his early twenties, majoring in philosophy. He came to see me, at the suggestion of an instructor, because he was completely bogged down in his academic work. Besides being stymied to the point of paralysis with the work on his honor's thesis, he also found it increasingly difficult to attend classes. He himself ascribed most of his difficulties, in a superficial, bland way, to a "problem of oversleeping." It appeared that he simply could not rouse himself in time to make his morning classes even though he used the desperate expedient of a battery of three alarm clocks which would go off at ten-minute intervals.

As Armand's story slowly and fragmentarily unfolded in therapy, it turned out that he was suffering from a whole string of obsessions and compulsions. Often he would be tortured by exhausting ruminations about trivial topics, which might go on for hours or even days. For example, when confronted with the task of writing a term paper, he might be compelled to deliberate interminably on the choice of the proper writing tool for his first draft—whether to use a typewriter or a pencil or a pen, what sort of a typewriter and what kind of a ribbon, or, in case he might feel inclined to use a pen, whether to use a fountain pen or a ball point pen, and what make of a pen to use; he was compelled to consider exactly the relative advantages of each writing tool, the dangers of smearing when using ink, the advantages and drawbacks of using pencils or colored pencils, the dangers, no matter how remote, of his pencil marks



fading or of his putting the pencil into his mouth and thus contracting lead poisoning, and so on. At times, he found it impossible to bring these excruciating deliberations to any sort of conclusion, and the paper would remain unwritten.

Like most compulsives, Armand D. was extremely diffident about mentioning and describing his more outlandish rituals. But in the course of therapy he detailed a number of compulsions, past and present, of which I shall mention only a few: (1) He has to make sure that dollar bills are right side up in his wallet. (2) He is compelled to throw a kiss to the tapestry whenever he crosses the threshold of his bedroom. (3) He has to go through an elaborate, exactly prescribed ritual whenever he takes leave from his fiancée. This ritual includes, among other things, that he has to rub his nose against hers in a peculiar way three times and that he must say "au revoir" to her just before leaving. (4) There are periods during which he is compelled to take five or more showers a day, soaping and brushing himself until his skin is lobster-red. After each shower, he has to inspect his body in a brilliantly lighted mirror. If this inspection reveals anything which looks like specks of dirt, he has to disinfect the suspect spots by liberal ablutions with Listerine. (5) He also mentioned a going-to-bed ritual, now extinct, which had transformed the evening hours into a veritable hell, for him and his parents, during many years of his childhood.

Besides the obsessional symptoms, there were also some somatic ones—in particular, severe migraine headaches. There was reason to believe that these headaches were of psychogenic origin. But Armand would radically reject such notions. He would remark, in his intellectualistic manner, that he preferred to think of his headaches as purely somatic. He believed that in this way he had more control over his symptoms, and control was all-important to him.

*Family background* Armand was the younger of two children. He had a sister, three years his senior, a hospital nurse, to whom he had been quite close in his early years, but from whom he was now rather estranged. He felt still more estranged from his father, a one-time druggist and of late a tax accountant, whom Armand described as a remote, shadowy, inconsequential figure. The salient fact about the father was that he was hardly ever home. He would travel a lot and spend his week-ends playing poker with some semiprofessional gamblers in a run-down shack. Armand felt "as if the old man had been dead for twelve years." The mother was described as a figure of much greater consequence. She had once "aspired to higher things," but had by now resigned herself to the role of a run-of-the-mill housewife. There was a period, a few years earlier, when the mother had carried on mightily, yelling and screaming a lot, threatening to kill herself and her "absentee-husband." Apparently, she had come to realize the futility of her revolt and had "gone on Miltown." In spite of her admission of defeat, Armand thought of her as a still mighty figure, endowed with witch-like demonic powers. He half believed that his mother could magically coerce the future, that her predicting a certain event would bring this event to pass. At the



time Armand first came to see me, his mother was indulging in all sorts of Cassandra-like prophecies about his marriage plans.

*Early childhood history* Armand was plagued by numerous physical ailments from early infancy. When he was three or four years old, there was a period when he was unable to retain his food. He would throw up regularly and was forced twice by the exasperated mother to eat his own vomit. At the age of five, he underwent surgery for a mastoid condition. He had been induced to go to the hospital by promises that he was only going to be examined, but suddenly found himself being strapped to an operating table. He put up a desperate and futile fight. He remembers being terribly frightened and staring into the bright sun-like lights over the operating table till he "went under." Upon awakening, he had an excruciating headache; he dates from that period the beginning of his migraine headaches and also of severe astigmatism which has forced him to wear thick glasses ever since. At the age of six, he was made to see a child psychologist because of persistent bedwetting. He was finally "cured," not by the psychologist, but by some gruesome technical contraption which would sound an alarm and jolt him with an electric shock whenever he wet his bed.

In the first years of school he was much of a loner, set apart, so he felt, by his bad eyesight and his physical puniness. Later in high school he managed to get in with a group of intellectual beatniks who would meet twice a week to read Russian novels and discuss abstract art.

Armand was mute on the topic of masturbation, except for mentioning that he discovered it fairly late. But he talked at length about some sexual play into which he had been initiated by his sister Eve when he was 11 years old. Eve would lie down flat on her belly, her torso naked, except for a pair of half-transparent panties. Then she would ask Armand to give her a back rub. Sometimes, when she was in a generous mood, she would turn around and let Armand fondle her budding breasts. One day, she abruptly decided that these pleasing games, into which Armand had entered with great zeal, were improper and ought to be stopped. Shortly thereafter, Armand felt compelled to institute his cleanliness orgies in the shower.

*Major problem areas* At the time Armand first came to see me, he had changed his major field of study twice. The latest change, at the end of his junior year, was from chemistry to philosophy. This change was calculated to annoy his parents, who would have liked him to enter one of the professions.

It took Armand an unconscionably long time before he let on that he was going steady with a girl, to whom he always referred as his "fiancée." Apparently, their friendship was quite platonic, but Armand felt uncomfortable about the mere fact of having a girl. An aggravating circumstance was that the girl was half-Chinese—aggravating, especially, in the eyes of his mother, a Catholic, who strongly disapproved of mixed marriages. To make matters worse, Armand, quite in style, was considering marriage by a Buddhist priest, according to an old Chinese ritual.

Like most compulsives, Armand was engaged in a ceaseless, never-

ending fight against "the authorities." During his psychological tests, he told, in response to a picture card, a Kafkaesque story about "Section Man" (with capitalized "S" and "M") which pretty much summarized his view about authority. It appeared that the hero of the story, "Armand D.," is about to enter a classroom when he is stopped by Section Man in his full and terrible majesty, who tells him that he may not enter. Then the story went on: "Armand D. asked: 'When may I enter'? The Section Man answered, 'You must wait'. Finally, he stopped asking. After many centuries passed by Armand D. asked once again, 'May I enter'? The Section Man answered, 'The lecture is over'."

Armand's whole life was a continuous war against "obligations." His oversleeping was symptomatic of this, as was his academic failure. He was fond of playing quite cruel practical jokes on some of the less dangerous authorities—and, for him, almost anybody his age or older was a potential "authority." In the presence of his professors, his attitude was a characteristic mixture of obsequiousness and quiet obstinacy. Once, after doing poorly on an exam, he daydreamed of revenging himself by forcing his instructors, at gun point, to abuse each other sexually. If the "authorities" were of lower-class origin, they were apt to be cast in the role of "gangsters." While working on a summer job for a toy company, he discovered such a group of "gangsters" who were posing as shipping clerks. He was keenly disappointed when, overhearing a conversation, he found out that these men had wives, mothers, brothers, sisters, sweethearts. Such conventional attachments, humanizing the men, were at odds with his image of whom he could respect as a strong-arm power.

His fiancée Joan, a quiet, unassuming girl, also was invested with the mantle of authority. On the surface, Armand was bothered by his overconcern about her. At least, that is how he interpreted his obsessional thought that sexual intercourse was bound to damage her organs. But in his dreams, he would, to his dismay, often torture Joan in a sadistic manner. In one particularly vivid dream, he forced a high pressure hose into Joan's vagina and then turned on the water.

The themes of filth, anality, and decay, while less overpowering than with some other compulsives, were also much in evidence. His elaborate shower ritual, the onset of which closely followed upon the sister's high-handed withdrawal from their forbidden games, mirrored his feeling of having sullied himself by his complicity. Later on, he dreamt repeatedly of pretty nurses giving him enemas, which would arouse him sexually. In other dreams, less pleasant in mood, his hands or feet would get stuck in a viscous, brownish, tar-like substance, which would cling to him so that he could not extricate himself. During one period of therapy, the word "green" kept obsessively haunting him for hours on end; at times, he even felt that the objects around him were impregnated with a greenish sheen. When asked to describe this color, it suddenly occurred to him that it was the color of a tuft of "sickening-looking" moss he had once seen hanging from a tree, and also like the color of the backparts of a cow smeared with dirty greenish dung, which he had observed during childhood. It then occurred to him that the color of his fiancée's car was

a "dirtyish green" and that this had always bothered him, whereupon he went into a lengthy tirade against "dirty women."

Some time later, Armand developed a passion for visiting the city wasteyard where the refuse of a large metropolitan area was collected and disposed of. One of Armand's hyperintellectual friends was working there on some menial job and would show him around. Armand watched with tireless fascination how the garbage trucks would pull up next to monstrously large pits and dump their odoriferous load. He began to ruminate about the relative merits of various systems of garbage disposal.

Thus the "anal-sadistic" label appeared to fit Armand's case. Armand also showed other features typical of the compulsive. For one, there was a pronounced megalomaniac streak. Once while holding forth eloquently on the corruption of Boston city politics—one of his favorite topics—a fellow student interrupted him with some irritation: "Who do you think you are?" Without a moment's hesitation Armand replied: "I am God!" He was also plagued by the absurd perfectionistic strivings which bedevil most compulsives and by deeply entrenched, though largely unconscious, guilt feelings which forced him to inflict painful forms of self-punishment.

*The partial recovery of the past* The therapeutic illumination of part of his forgotten "prehistory" made it appear likely that there had been, indeed, a fierce battle about toilet training. (It would have been desirable to have this authenticated by the mother or sister, but this was not feasible.) At any rate, Armand dug up some early memories, according to which he had been given a series of enemas by his mother when he was about two and one-half to three and one-half years old, and he thought he could remember that similar ministrations at a somewhat later age aroused strong pleasurable feelings in him. His associations suggested that he experienced this enforced emptying of his bowels at the same time as an act of high-handed robbery and as some piece of exciting sexual business. Hence there followed later his decidedly sexual dreams about pretty nurses introducing rubber tubes into his rectum.

Therapy also unearthed rich Oedipal material. After a few months of treatment, Armand began to bring in clearly sexual dreams in which the mother had taken the fiancée's and the sister's place. It became obvious that his physical coldness and undemonstrativeness toward the mother, which he saw as the result of her "lack of femininity," was partly a cover-up for repressed incestuous feelings that had retained much of their earlier virulence. In childhood, at any rate, he had not thought of the mother as devoid of feminine attraction. It turned out that one of his childish going-to-bed rituals, which included the necessity of open bedroom doors and turned-on lights, had as its purpose to keep the mother "out of father's clutches" and to force her to remain aware of Armand's presence. The father himself, so casually described as an inconsequential bungler, assumed the earlier shape of a tremendously powerful, potentially dangerous figure, whose mere voice could make a little boy tremble. But somehow the little boy had managed to outsmart Goliath and taken away his wife, or so Armand believed, who saw the later estrangement between the parents as of his doing; in this way, while feeding his sense of power, he had also saddled himself with an unbearable burden of guilt.



## PERIODICITY OF OBSESSIONAL SYNDROMES

As far as the temporal course of individual cases of obsessional neuroses is concerned, one often notices a certain periodicity: at one time, the defensive, expiatory aspects of obsessional syndromes dominate the clinical picture, to the point where the repressed impulses are hardly visible; at other times, these impulses manage to push themselves to the fore and to emerge in only threadbare disguise. Frequently, such a breakthrough of initially masked impulses goes hand in hand with a general worsening of the patient's condition. Two examples from Fenichel (1945) illustrate this increasing "clarification" of symptoms which seemed, at the outset, to stand completely in the service of the defensive maneuvers:

A patient felt remorseful after taking gymnastic exercises. Analysis showed that the exercise represented masturbation. Then this remorse, with which he had come to terms in an obsessional manner, finally made him think: "Now masturbate, and ruin yourself completely!" and he was compelled to masturbate several times in succession without any pleasure.

The second case was that of a woman who suffered from so extreme a phobia against dirt that she remained in bed all day when she had the feeling that her clothing or the room in general was dirty. Her fear of dirt, on these days, would prevent her from leaving the bed at all, with the result that eventually she arrived at the point where she actually did soil the bed (p. 271).

The phobic element (dirt phobia) which is so evident in this case is seldom missing from the picture of obsessional neurosis. Indeed, obsessional neurosis as a rule is preceded by a more or less fully developed phobia, the fragmented vestiges of which can be clearly demonstrated in the obsessional syndrome which replaces it.

## THE TEMPORAL STRUCTURE OF THE OBSESSIONAL WORLD

The psychoanalytic attempts to arrive at a psychodynamic formulation of obsessional neurosis have been complemented by the efforts of the so-called phenomenological psychiatrists who strive primarily to give a minute description of the immediate "feel" of the obsessional world. Psychoanalysis with its emphasis on theoretical mastery tends to leave out the data which do not fit into its schemata, thus impoverishing reality. In its eagerness to get at the "underlying mechanisms," it risks losing sight of the immediately given phenomena. It is the merit of close descriptive ("phenomenological") investigations that they heighten our awareness of the inexhaustible richness in the foreground of psychopathological phenomena and of the—when all

is said and done—mysterious opacity of their background. In this way, the phenomenological emphasis can prove an effective antidote to Freudian schematicism, as long as it avoids the opposite danger of getting lost in a flood of chaotic detail.

Among the phenomenologically oriented investigators, it has been von Gebattel (1958) who has explored most minutely the world of the *anankast*—as he calls the compulsive. Von Gebattel has focused on an analysis of the temporal structure of this world, which he feels to be most revealing. According to him, the compulsive is characterized by a “staccato” style of action which, with its mania for precision and detail, transforms him into a robot. He is also characterized by an over-all stagnation, by a lack of movement in his life history. He is, as von Gebattel puts it, “nailed to his past” and deaf to the call of the future with its beckoning opportunities and tasks.

Von Gebattel establishes a link between this arrest of Becoming and the sense of dirt and pollution which infests the world of the compulsive. He suggests that this fundamental pollution is in the last analysis the stagnation of Becoming. What matters from this perspective is not so much the particular symptom—the fixed idea of having an offensive body odor, for example—in which the sense of pollution manifests itself but rather that we are here in the presence of an existence which has lost its means of purification from the past and its devotion to the challenges of the future. The healthy existence continually discards the past, leaves it behind, drops its unassimilated parts. Life cleanses itself by this process of excretion. But it is just this surpassing of the past that the *anankast* is incapable of; for him, “the past does not take on the past perfect tense,” and he cannot rid himself of it. As something unfinished, it exerts pressure and makes demands upon him as the future makes demands upon the healthy person, and it is this fatal adhesion to the past which pollutes and envenoms the compulsive’s existence.

Von Gebattel relies more on vague metaphysical speculation than on concrete clinical demonstration in order to prove his thesis that the arrest of becoming, the hampering of “temporalization,” is the basic disturbance of obsessional neurosis. (In other neurotic, and in psychotic syndromes, a deficiency of temporal unfolding would play, presumably, an equally fundamental role but would be of a different type, specific to a given syndrome.)

Even if one does not follow to the end von Gebattel’s analysis, one may yet want to admit that the dimension of subjective time is clinically powerful and that it is worth our effort to study the tem-

poral structure of various normal and abnormal worlds. Such an effort is not without precedent. Descriptive psychology has been aware, for quite some time, of the variations of the subjective experience of time in connection with pathological changes in mood (Jaspers, 1953, pp. 69-74). Thus the performance and reaction times of the depressed are not only slowed down objectively, but time seems to flow more sluggishly to them. It has been reported repeatedly that in certain hyperactive (manic) states, time appears to become volatile, to evaporate. Binswanger has described the "skipping, leaping" style of life of the manic whose subjective time becomes fragmented and discontinuous, while Minkowski (1933) has depicted the empty eternity of the schizophrenic who feels as if time were fixed at the present moment, with his ensuing delusion of immortality. Such attempts, even in their present rudimentary form, enrich our understanding of the abnormal person and thus increase the likelihood of therapeutic communication.

#### PROGNOSIS AND TREATMENT

It is widely held that the prognosis for obsessive-compulsive neurosis is unfavorable, that these conditions tend to worsen progressively, and that spontaneous remissions are very rare. However, some recent follow-up studies throw doubts on this evaluation. Thus Mueller (1953) reported a follow-up study of 57 compulsives who had been seen in two clinics in Zurich. The period between the first contact with the patient and the follow-up interview averaged 25 years. At the time of the follow-up, the average age of the patient group was 55 years. About half of the patients had notably improved over this period of time, a number of them spontaneously, others while receiving psychotherapy. Altogether, 28 per cent of the group were free from obsessional symptoms at follow-up and were described as "socially adapted, working at full capacity, and happy in their family lives." A further 21 per cent showed a marked decrease of symptoms; they were characterized as "socially adapted, able to work, with relatively good interpersonal relations." At the other end of the spectrum, there were 7 cases out of 57 who had deteriorated to the point of schizophrenia. Mueller's investigation seems to confirm an earlier follow-up study by Lewis (1936) who, using symptomatic changes as his only criterion, found significant improvement among 46 per cent of his group of 50 patients.

As far as the psychotherapy of obsessional syndromes is concerned, it is generally difficult and drawn out. It usually consists of



an exploration, along psychoanalytic principles, of the patient's unconscious and his early life dynamics.

The reasons for the relative refractoriness of the compulsive neurotic to therapy are fairly clear. As we have seen, it is the essence of the compulsive that he labors under a fantastically overgrown need for security, and in his efforts to attain it, he makes use of a great many of the various tactics available in the large arsenal of defensive maneuvers. As we also have seen, one of his favorite tactics is an "intellectualization" by means of which he tries to turn the therapeutic endeavor into an arena of cerebral acrobatics and theoretical-intellectual disputation with the therapist. His defensively hypertrophied intelligence serves him well in this endeavor, which is also favored frequently by the intellectualistic climate of psychoanalysis. If such a patient happens to run into an intellectually ambitious, contentious therapist, he may be able to play his little games forever.

A unique difficulty in the treatment of obsessive intellectualizers lies in the fact that they invest words and ideas with intense emotion—"sexualize" them, in the psychoanalytic jargon; but words and ideas are also the primary medium of therapeutic intervention. Thus the patient finds himself in the fatal situation of the man who fell "into the water with a towel in his hand," and the therapist is now "trying to dry him with the towel which had become wet along with his body" (Fenichel, 1945, p. 310). In other words, the medium of therapeutic action is itself contaminated.

This means that it is all but impossible for the compulsive to live up to the fundamental rule of psychoanalysis: free association. His conscious processes are too tightly controlled, and only with great difficulty does he gradually unbend. This is also a reason why therapy with compulsives is so time-consuming. Hundreds of treatment hours can go by before such patients finally have the courage to yield more or less passively to the spontaneous flow of associations. Indeed, when they have come this far, a large stretch of the therapeutic road already lies behind them.

All these therapeutic difficulties do not preclude significant treatment results. Treatment tends to be protracted, to be sure, but perseverance is sometimes magnificently rewarded by the setting free of creative energies which previously had been tied up in sterile defensive machinations.

# 5

## Psychosomatic Disorders

The term "psychosomatic" has various meanings. In a general way, it is used to refer to organic (somatic) diseases which are partly "non-organic" in the sense that in their etiology *emotional* factors are held to play a significant role. In its stricter, technical usage, "psychosomatic" applies to a more or less well-defined group of somatic disorders for which the etiological significance of psychic factors has been demonstrated quite convincingly in a large number of cases. To this group of "psychosomatic diseases" belong peptic and duodenal ulcer, essential hypertension, bronchial asthma, migraine headaches, ulcerative colitis, arthritis, and various forms of skin disease (neurodermatoses). Sometimes, "psychosomatic" is used more loosely to refer also to chronic organic diseases with a complex psychic overlay (such as tuberculosis) the course of which may be noticeably affected by psychic factors, but in the etiology of which such factors play, if at all, only an obscure, ill-defined role. A few authors extend the range of meaning of "psychosomatic" even further, applying it to practically any form of organic disease, whether it be cancer or trichinosis. This overinclusive usage commonly contains as its only ascertainable element of meaning a vague belief in the causal primacy, the etiological omnipotence, of psychic happenings.

*The incidence of psychosomatic disorders* Obviously, one's incidence figures for psychosomatic disease will depend on the definition of "psychosomatic." But by any definition, except for the meaningless all-inclusive one, our statistics have registered, in recent decades, a marked increase of the incidence of such disorders. Halliday (1948) links this increase with social and cultural changes that seem to favor

obsessional personality types and the kinds of "somatization" reactions often shown by them. Ehrstrom (1951), investigating Eskimos in Greenland, has reported such reactions to be strikingly more common among those exposed at close quarters to the influences of Western culture. Some authors have not hesitated to talk, in this connection, of diseases of civilization.

While large-scale, epidemiological observations for our own society are not available, we have a number of smaller studies involving samplings of patients who came to medical clinics with somatic complaints. These studies found incidence rates of psychic disturbances varying from 34 per cent to 80 per cent. At the high end of this range were the figures of Lewis (1953), who carefully studied 163 consecutive patients at the private outpatient clinic of Johns Hopkins Hospital and found that 49 per cent were suffering from disorders which he considered to be purely psychological in origin, and a further 27 per cent from disorders to which he ascribed a mixed organic and psychic etiology. Thus 76 per cent of his population were suffering from diseases, mostly chronic in nature, in which emotional factors played an important etiological role. While the majority of the patients in Lewis' group were middle and upper class, a study by Roberts and Norton (1952) involving patients of distinctly lower social status—outpatients in the clinic of a general hospital—found almost the same incidence (80 per cent) of medical cases in which emotional problems loomed large. A much lower incidence (40 per cent) of somatic disorders with emotional determinants was observed by Allan and Kaufman (1948) who among 1000 general medical cases from the Lahey Clinic diagnosed 272 as being of psychological origin, and 134 as being due to a combination of somatic and mental factors. Their sample consisted of a random series of ambulatory patients who had come to the clinic for a general checkup.

Dunbar, summarizing various studies, estimates that psychological factors loom large in the etiology of approximately two-thirds of the cases seen by the general practitioner. Jores (1956) points out that at least 1500 of the roughly 2000 diseases which are known to afflict human beings have origins which are, to a large extent, unexplained. It would be obviously unwarranted to assume that all these sicknesses with unknown etiology have a psychic origin even though this sort of "negative diagnosis" is much in vogue at present; yet emotional stress of one kind or another may turn out to be a major precipitating factor among many of these diseases.



*The Bodily Reverberations of Intense Emotions*

We have defined psychosomatic disorders as organic diseases of partly psychological origin. They may be attributed, in part, to the neurotic miscarriage of intrinsically normal psychic and physiological processes. They may be caused, more specifically, by an inadequate discharge of strong emotions. Intense emotions are organismic tension states which involve such somatic concomitants as increased blood pressure and pulse rate. These tension states demand expression by means of appropriate physical or symbolic actions, after which pulse rate and blood pressure will return to normal. If, however, for whatever reason, this natural discharge is inhibited repeatedly or unduly delayed, then the tension state will not dissipate and the normally transient phenomena of heightened blood pressure and increased pulse rate will extend far beyond their normally appointed term, with the result that severe strain is imposed upon the delicate equilibrating devices of the organism. Such strain, if much prolonged, may eventually lead to serious cardiovascular accidents, such as the rupture of a blood vessel. We shall use below the example of peptic ulcer to illustrate in some detail this close entanglement of physiological mechanisms with emotional states.

But first let us document the far-reaching influence of psychic factors on somatic processes by means of some more extreme examples culled from the literature on hypnotic experiments. Hypnotists have been able to produce "psychic burns" complete with blisters and subsequent scars by suggesting that a red hot coin is laid on the skin. Hypnotic suggestion has been shown to raise the body temperature to the point of fever, to lead to the healing of warts, to shorten or prolong the menstrual cycle. Even the biochemical processes of metabolism can be measurably affected by hypnotic suggestion. And while the hypnotic raising of blisters may be a matter of some controversy, it is generally acknowledged that hypnosis can induce almost total insensitivity to pain.<sup>1</sup>

Anecdotal evidence illustrating the somatic reverberations of strong emotions is supplied by authors who report that an apparently healthy organism can literally be put to death by mere suggestion. An often cited example is that of the Voodoo deaths of primitives who have

<sup>1</sup> Some of these effects are put to work in the therapeutic method of "autogenic training" (Schultz, 1960) which brings about "psycho-somatic" relaxation by means of a self-induced quasi-hypnotic trance. The method claims remarkable curative effects with mild forms of neurosis and psychosomatic illness.

violated a sacred taboo or have been "hexed" by a tribal magician. Richter (1957) notes that similar phenomena are not unknown in our own culture. He reports that each year in this country a number of persons succumb who have swallowed a sublethal dose of poison or have suffered a minor, normally nonfatal wound, apparently as a result of their firm belief that they are fated to die. The brilliant, but not always reliable, Groddeck (1923) described a most unusual process when he related premature graying to the assumption of a "father mask" (facial identification with the father) and pointed out that he had several times observed grayness coming on and then vanishing again.

But let us return to less outlandish matters, namely, the formation of a genuine psychosomatic symptom in the guise of a peptic ulcer. It is generally held that the immediate organic cause of such ulcers is overactivity of the stomach involving, among other things, hypersecretion of gastric acid. Now secretion of gastric juice is a normal part of the digestive process which is commonly set in motion by the ingestion of food or, in the case of a hungry person, by the mere thought of it. The physiological mechanisms leading to ulcer formation are basically the same as those that play in the normal assimilation of food. But in the ulcer case they occur out of phase, when no food is present, and hence result in the partial self-digestion of the stomach. The critical question is: what mobilizes these stomach activities and keeps them going, independent of any physiological hunger or feeding? One answer would be: perhaps some sort of symbolic or emotional hunger, a craving for care and attention, or some similar, probably not fully acknowledged, emotional need. It is clear that the individual's life history, starting with the earliest period of nursing, offers plenty of opportunities to effect this linkage between feeding and the larger complex of being mothered, fondled, taken care of. Thus, in the case of the human being, the act of feeding, like the exercise of other basic bodily functions, can never be looked at as a mere physiological act. It is enriched with an overgrowth of complex symbolic meanings. And in actual fact, repressed cravings for the milk of motherly love have been found to be a driving force in the emotional economy of many peptic ulcer patients.

The primary business of the stomach is with the feeding complex. However, as a sensitive visceral organ, it also vibrates with other emotions, such as anxiety or anger, especially if they reach a high pitch of intensity. The degree of gastric involvement, and the exact patterning of autonomic responses, differ from person to person. But

it is known that with some individuals, at least, a chronic exacerbation of fear or anger can also trigger the mechanisms which eventually lead to the formation of gastric ulcers.

A pretty demonstration of the participation of one man's stomach in his feelings of fear and anger was provided by Wolf and Wolff's (1942) famous case of Tom. This subject, in his robust fifties at the time of Wolf and Wolff's observations, had suffered early in life an injury of the esophagus which made it necessary to feed him from then on through a surgical opening (gastric fistula) in the abdominal wall. A collar of gastric mucosa had protruded around the fistula, thus exposing to direct view a piece of tissue essentially similar to the stomach lining. To the delight of his observers, Tom turned out to be a visceral type whose stomach vigorously shared in his emotional life. Whenever he felt intensely angry or resentful, the exposed piece of tissue would redden, due to an engorgement with blood, whereas it would noticeably discolor whenever fear or dejection was the dominant mood. Thus, this expressive fragment of mucosa would signal abroad, like a piece of litmus paper, the emotional state of this man.

Incidentally, Wolf and Wolff also used Tom to demonstrate some of the mechanisms of ulcer formation. They produced an artificial ulcer by subjecting a small, slightly eroded spot of the exposed tissue to the continuous action of Tom's own gastric juice. Within twenty-four hours the first clear-cut symptoms of ulcer formation appeared. The lesions produced in this way would heal spontaneously after the application of a protective dressing that prevented further contact with the gastric acid. Wolf and Wolff observed that Tom was not the type who would grow ulcers naturally because he was unable to harbor grudges or to maintain emotional stress for prolonged periods. "Usually he expressed his feelings either in words or in actions, and his more serious conflicts were relatively short-lived." In line with this observation, the emergency periods during which the stomach was engorged with blood and otherwise overactive turned out to be relatively transitory. This man did not need to develop an ulcer because he did not do much violence to his emotions.

### *Basic Differences Between Psychosomatic and Neurotic Disorders*

To what extent do psychosomatic disorders differ from neuroses, especially from conversion hysteria which also involves organic



malfunction? Are the mechanisms of symptom formation in a peptic ulcer case basically different from those at work in hysterical blindness? Some authors feel that such differences are minimal; hence they deal with psychosomatic illness under the general heading of neurosis. The majority of workers, however, pointing to fundamental differences in psychodynamics and organic involvement, contend that psychosomatic disorders need to be treated as a category *sui generis*. In this connection, a number of distinguishing criteria have been proposed:

1. A difference with regard to the handling of neurotic anxiety. Hysterical symptom formation usually alleviates or swallows intense anxiety whereas psychosomatic symptoms are notoriously less successful in this respect. The "belle indifférence" of the hysteric is rarely to be met with in psychosomatics. The latter frequently are poorly endowed with operating neurotic defenses. A peptic ulcer may be a consequence of neurotic anxiety, but it does little to relieve such anxiety.

2. A difference with regard to anatomic localization. Hysterical symptoms mainly affect those areas of the body controlled by the central nervous system—primarily the sensory and motor organs—whereas psychosomatic disorders largely affect the organs controlled by the autonomic division of the nervous system, in particular the cardiovascular, respiratory, and digestive tracts.

3. The presence of a lesion. A peptic ulcer involves damaging crater formation in the stomach lining. Hysterical symptoms usually do not entail physical changes in organs or organ systems but only affect the manner of their functioning. There is no demonstrable structural damage to the visual apparatus in the case of an hysterical blindness.

4. The fit of the symptom to physiological laws. Psychosomatic symptoms respect the laws of normal organic functioning, hysterical symptoms often do not. Thus a duodenal ulcer or a hypertension condition, affecting as they do a delimited organ or organ system, makes anatomical sense; a hysterical "glove anesthesia," however, involving an insensitive area ending sharply at the wrist, is anatomically absurd. The distribution of sensory nerves is such that no possible local injury could give rise to an anesthesia delimited in this fashion. Similarly, an hysterical heart case may not be able to point to his heart correctly but tries to. A psychosomatic cardiac says he hurts elsewhere, as a coronary patient says.

5. The immediate organic agent of the psychosomatic illness is always a normal organic mechanism. The secretion of acid by the stomach is part of the normal process of digestion; the ulcer case puts this digestive device to less dignified uses. Not so with neurotics. Devices not usual to the body are invented.

There are additional criteria which differentiate between psychosomatic illness and conversion hysteria. None of the above criteria by itself can claim absolute validity. But, as a rule, several or all of them apply in conjunction. Hence it is appropriate to consider psychosomatic illness as a category in its own right, and not as a mere subdivision of psychoneurotic conditions.

### *The Choice of Illness and the Choice of Organ*

Why do some people cope with stress, conflict, anxiety by means of neurotic reactions whereas others, under similar circumstances, develop psychosomatic symptoms? Are there certain personality factors which predispose to somatization reactions? If there are, we have failed to isolate them so far. The most that can be said is that psychosomatic disorders are frequently found in obsessional personality types who may hide a rather shaky ego structure behind a deceptive façade of supernormality. Psychosomatic patients tend to be "pillars of the community"—hard-working and hard-driving, with an acute sense of their social responsibilities. But this appearance of maturity may be quite misleading. Many clinicians assert that a considerable number of peptic ulcer and ulcerative colitis patients—to name only two categories of psychosomatic patients—are characterized by extremely intense, repressed dependency needs. Once these needs are brought into the open by psychotherapy, the seemingly mature patient may regress rapidly to a stage of psychotic helplessness. Hence some therapists are reluctant to engage in any probing of the unconscious depths with such patients.

Within the domain of psychosomatic medicine, the question of the choice of organ has attracted much attention. Why do psychic disharmonies materialize in the form of a cardiac neurosis with one patient, and in the guise of a duodenal ulcer with another? Are there any specific factors which determine the choice of organ?

Three major theses compete to explain this problem:

1. The first thesis holds that the disorder crystallizes in a *locus minoris resistentiae*, an organ which is constitutionally vulnerable, or

has become vulnerable in the course of the life history. Physicians of the early Christian era talked of the "sympathetic" receptiveness of certain organs, predisposing them to resonate with psychic afflictions. Generally this thesis of the susceptible organ appears in the garb of constitutional or hereditary theories. This is scarcely a logical necessity. It is equally plausible to assume that organ vulnerability is determined by the life history, is acquired rather than congenital. This thesis of the susceptible organ by itself is no longer considered adequate to account for psychosomatic conditions.

2. Dunbar, among others, has suggested that the choice of organ is determined by personality type. This thesis enjoyed considerable popularity for a time, but failed to stand up under the burden of cross-validation.

3. The "theory of specificity," proposed by Alexander and his co-workers, sees the determining factor of organ choice in specific constellations of psychic conflict rather than in personality types. Thus peptic ulcer is said to point to the specific constellation of a dependency conflict in which strong repressed wishes for infantile security hide behind a façade of exaggerated autonomy. Similarly, a conflict about the expression of pent-up hostility is said to be the primary psychic correlate of essential hypertension (see below). Alexander and his co-workers have tried with great diligence to substantiate this hypothesis empirically, but with dubious success. At present it is very much an open question whether the correlation between type of conflict and organ choice is dependable and specific.

An evaluation of this and similar theories is made difficult by the fact that the conflict situations under consideration are much too general and inclusive. Thus, repressed, overcompensated desires for dependency can be shown to exist, and to play an important role, in the psychic economy of almost every neurotic in the Western world. Similarly, conflicts around dammed-up aggression are quasi-universal in the neurotic personalities of our culture—and in normal people as well. It is true that, with some clinical cases, one or another type of conflict can easily be seen as dominant or particularly acute, but for each such case there are many others where a decision that a particular conflict predominates is bound to be arbitrary. This whole problem remains insoluble as long as we are not able to isolate much more specific, well-delineated themes of conflict, with a minimum area of overlap. The "specificity of conflict" theory in its original form is no longer acceptable to most contemporary workers.



Of the three theories of organ choice here presented, none has been able to establish itself to the exclusion of others. Combinations of several of their features are often encountered in present-day attempts to deal with this thorny problem (see below).

It seems useful to illustrate what has been said up to now by a closer look at some specific syndromes. For both theoretical and practical reasons, we choose as our examples the conditions of essential hypertension and bronchial asthma.

### *Essential Hypertension*

According to statistics of the Metropolitan Life Insurance Company, quoted by Weiss and English (1957), every other individual in the United States past the age of 50 years dies of cardiac or vascular disease. Other statistical sources suggest that approximately half of these deaths are due to hypertension. This means that "almost one quarter of all people past the age of 50 years die of the effects of hypertension in one or another of the vital organs. Thus hypertension becomes the gravest problem of middle adult life, not even excepting cancer" (Weiss and English, 1957, p. 225). Having been studied thoroughly on an abundant case material, essential hypertension has given rise to a plethora of interesting theoretical formulations and controversies.

Essential hypertension is the term used to designate chronically high blood pressure in the absence of clear organic pathology. Its inception is demonstrably associated with psychic factors; headaches and general dizziness are the most frequent symptoms of this disease, which can lead to fatal vascular accidents or heart failure.

In the literature, a connection is often made between essential hypertension and feelings of rage or anger which have been inadequately dealt with. It is pointed out that such characteristic symptoms of the disease as acceleration of heartbeat and vasoconstriction are somatic components of the rage reaction. Some investigators claim that other emotions, such as anxiety and chronic depression, produce similar somatic symptoms. However, Ax (1953) and other workers report that blood pressure tends to be affected more decisively by "anger situations" than by "fear situations."

Workers in psychosomatic medicine have spent a great deal of effort in order to define a personality type or a conflict constellation peculiar to hypertension. These efforts have not been very successful.

Again and again the important role of suppressed rage in these patients' psychic economy has been noted, and the fact that they tend to be compulsive perfectionists, who hide a great deal of resentment behind a façade of exemplary, if somewhat acrid, gentleness and kindness. The trouble is that these are fairly general features, to be met with also in other types of disorders. As soon as one begins to narrow down one's psychodynamic formula, a significant number of hypertensives no longer fit into it.

In his investigation of hypertension, Menninger (1938) stressed the part played by inward-directed, self-destructive aggressiveness. Numerous investigations emphasize the importance of unfulfilled, unacceptable dependency needs which give rise to sharp ambivalence conflicts with the dominant parent (Reiser *et al.*, 1951). The overpowering dependency needs of these patients make it very dangerous for them to give free vent to their aggressions (Binger *et al.*, 1945). They are fearful lest an outbreak of their subterranean, smoldering hate lead to desertion by the desperately needed partner. Once again, however, this conflict configuration is not specific to hypertension, and can be met in other emotional disorders.

In an attempt to specify the conflict pattern of hypertensives more closely, the psychoanalyst Saul (1939) focused on the status of the aggressive impulses in these patients. He concluded that these impulses were only half unconscious, less radically repressed than in the typical neuroses, nearer to the surface of consciousness, and hence the more threatening and the more in need of tight control. Saul saw in this peculiar midway position of the aggressive impulses the distinguishing feature of the hypertensive. Unfortunately, his findings were based on only a handful of patients whose life histories had been explored for a scant few hours. Certainly his formulation was exemplary in that it pointed the way toward greater specificity; it was well enough defined to make it subject to proof or disproof by empirical test. This may have been one reason that subsequently nothing more was heard of it.

Wolf and Pfeifer (1948) were struck by the muscle tensions usually to be found in hypertensives, which give these patients the appearance of being constantly mobilized for mortal combat. They impressed these authors as being, underneath the mask of affability, always poised to strike, and at the same time compelled to withhold their punch, with a guilty fear of its consequences. In the life histories of most of these patients, a mother who never tolerated tantrums was

said to play a great role. Hence, they were noticeably shy as children and tended later to choose a self-controlled spouse.

Dunbar (1959), in formulations reminiscent of Saul and of Wolf and Pfeifer, noted that in many hypertensives "resentment is near the surface and little elaborated psychically. There are some patients who will tell you 'I always say "yes," I don't know why. Afterwards I am furious'. Sometimes they show this feeling in the characterological armor or muscle tension which decreases as the inhibition of these impulses decreases. But there are patients who look completely different. They may seem to be libertines" (pp. 117-118).

The next to the last sentence in this statement is perhaps the most important: "There are patients who look completely different." The more one examines the voluminous research literature, the more one is impressed by the variety and contradictory nature of the results. E. Weiss (1950), in a thorough review of the literature, came to the resigned conclusion that all character types and all kinds of neurotic disturbances occur in conjunction with hypertension. But he also stressed that compulsive features appear with particular frequency, and it is generally agreed that such features point to repressed aggression. We can therefore be quite sure that hypertensives, as a rule, are compulsive characters. (Of course, we cannot assert the inverse: that all compulsives suffer from hypertension.)

#### AN EXISTENTIAL-ANALYTIC FORMULATION

A specificity theory which is couched in existential-analytic terms has been advanced by Boss (1954). He noted that hypertension and related disorders are found to be remarkably frequent among groups whose members are exposed to unusual social pressures. In the United States, for instance, ambitious, socially mobile, second generation Americans of lower-class origins are especially prone to develop hypertension. This also holds true for television and movie stars, Hollywood and Broadway producers, and all those dependent on the vagaries of public taste and acclaim, who amidst the most munificent trappings may be skating on treacherously thin ice. Boss also quotes the figures of Schwab and Schulze (1932) who found that Negroes in the American South were two and one-half times as likely to develop hypertension as Southern whites, and, moreover, were apt to suffer from more dangerous forms of the disease. These incidence figures for American Negroes were contrasted with those for African Negroes among whom hypertension



is unknown. From this and a host of similar observations, Boss concluded that one crucial feature in the life situation of hypertensives is the "being-exposed" or "being-under-pressure."

According to Boss, this analysis is borne out by psychotherapeutic work with individual hypertensives. Therapeutic exploration shows that these patients are not only laboring under extraordinary pressures, but that they also tend to add to these pressures by being extraordinarily restrained and self-controlled. They are characteristically unable to release steam, to give vent to their feelings of rage, oppression, or frustration. Boss contrasts the hypertensives with the group of accident-prone neurotics who are said to labor under similar pressures, but who, unlike the stoic hypertensive, react to such tensions with frantic attempts at escape which then culminate in more or less serious accidents. It is then the combination of "being-under-pressure" and of superhuman self-restraint which is said to characterize the hypertensive. In Boss's metaphorical language: the hypertensive is "walled in alive."

Boss graphically describes the prison-like existence of these patients in whom "a mighty, expansive stream of life is dammed up behind a thick façade of self-control, amiability, and propriety." At the same time, he continues, their "blood stream is subjected to ever rising pressure in the contracting prison of thickening, calcifying vessels: so lives this kind of hypertensive till finally something which is filled to bursting bursts. What breaks in such a patient is not, as in the case of the accident prone, a peripheral bone or some muscle tissue draped over it, but rather—in accord with his life style of stoic forbearance—a blood vessel deep and secret in the body which, in bursting, releases him from the too heavy burden of earthly existence" (Boss, 1954, p. 151).

On closer inspection, Boss's formulations are not radically different from those of the psychoanalysts, even though the language differs. Boss stresses the etiological importance of the same factors which Alexander, Menninger, Reiser, Binger, Dunbar, and others have emphasized—perfectionism, obsessiveness, repressed anger, general paralysis of self-expression—and his hypotheses suffer from the same shortcomings as theirs: a lack of precision. The only marked differences lie in the philosophical underpinnings of Boss's theory and in its descriptive bent which emphasizes the existential situation of the individual. The parallel between the calcification of the blood vessels and the existential "being-walled-in" of the hypertensive is certainly suggestive; whether it is more remains to be seen.

### *Bronchial Asthma*

Asthma is a condition marked by short breath, coughing, and wheezing, which may culminate in dangerous paroxysms of breathlessness. An asthma attack may last from a few minutes to several days. The immediate organic causes of such attacks are the obstruction of air passages due to spasm, hypersecretion, and swelling of the lining membranes of the smaller bronchial tubes.

Asthma attacks can be precipitated by the inhalation of "allergens," that is, substances to which the breathing apparatus is oversensitive. They can also be triggered by specific situations of emotional stress. Asthma can be cured by chemical de-sensitization or by psychotherapy without chemical intervention. While in some cases physiological factors and in others, psychological ones, clearly predominate, it has proved impossible to make a clear distinction between allergic and psychogenic asthma groups. Many patients who at first sight appear to be pure allergy cases turn out to respond also to emotional stimuli, and vice versa. The area of overlap is considerable. A case in point is that of an asthma patient whose attacks were shown to be allergic reactions to the pollen of primroses; but identical attacks could be induced when the patient was told under hypnosis that he was surrounded by primroses (Hendrick, 1958, p. 285). In a careful study of 79 adult female patients, Dekker, Barendregt, and De Vries (1961) found that apparently allergic and apparently non-allergic patients scored equally high on a measure of neuroticism—and significantly higher than a normal control group. Their conclusion that neurotic factors are present in most asthma patients, whether initially classified as allergic or psychic, was supported by the findings of Knapp and Nemetz reported below.

#### LABORATORY-PRODUCED PSYCHIC ATTACKS OF ASTHMA

That psychic attacks of asthma can be produced reliably under controlled laboratory conditions was demonstrated by the experiments of Dekker and Groen (1956), who used twelve patients suffering from severe asthma as their experimental group. These patients had described specific real life situations, frequently of a somewhat bizarre character, which would precipitate asthmatic attacks.

A few examples of such asthma-provoking situations follow:

A female patient A gets a sense of constriction merely by *looking* at dust, but only during the hay-fever season.

An asthmatic boy B exhibits shortness of breath when the sun shines into his room; he then sees the dust particles float in the sunlight. When there is no sunshine, he has no symptoms in the same room.

Another female patient C becomes short of breath when listening to radio speeches by a certain prominent political person or to the broadcast of a children's choir, or when she hears the national anthem.

A jewelry salesman G frequently becomes short of breath when lifting his sample bag.

Patient J, a young woman, feels "suffocated" when she visits her father's grave, but only when her mother is there too.

Two other patients, L and M, stated that looking at a goldfish in a bowl caused an asthmatic attack. Both these patients reacted in a similar way when watching a bird in a cage (*ibid.*, pp. 210-211).

The main criterion of patient selection was that the asthma-provoking situation could be mimicked in the laboratory. The twelve chosen subjects were first familiarized with a neutral laboratory setting and then exposed to the critical stimuli. Continuous physiological measures of breathing ("vital capacity" measures) were taken. The result was that half of the group (six patients) did not react at all when subjected to the presumably "asthmagenic" (asthma-inducing) stimuli; the remaining half showed noticeable disturbances of breathing which in three cases resulted in clear-cut asthmatic attacks.

Two of the three cases that produced frank asthmatic attacks were the two women L and M who had stated that they were "allergic" to goldfish. Both patients, reacting in an almost identical manner, documented the truth of their allegations by starting to wheeze loudly when a goldfish in a bowl was brought into the laboratory room. After the removal of the bowl, the attacks promptly subsided. The result was the same when a plastic toy goldfish was presented. The toy was easily recognizable as such, and patient M even severely chided herself for "choking because of that silly toy thing. It isn't even alive." In the case of patient L it was subsequently shown that even the sight of the empty bowl could induce a severe asthmatic attack.

Both patients spontaneously related traumatic experiences and emotion-laden fantasies under the spur of the provocation tests. Thus patient M, when first sighting the goldfish, began excitedly to re-



proach the doctor for keeping the poor creature jailed. She could not get away from the idea that the fish was suffocating and gasping for breath behind the glass. When her artificially induced asthmatic attack was near its height she suddenly recalled her first attack which had occurred eight years earlier than she had previously remembered. It started when her husband, a butcher, had made her mop up the blood of a slaughtered calf from the floor, just after her marriage. The recall of this painful scene led to a violent emotional outburst, accompanied by increased gasping for breath. The exposure to the toy goldfish induced a similar pouring forth of traumatic memories and raw emotions.

Dekker and Groen report that these psychic asthma attacks could be reproduced more than once. They do not relate how many such reproduction trials they undertook and whether, after a long series of repetitions, any extinction effects, similar to those in chemical desensitization, were noted.

It is of interest that a high intensity of emotion in itself was not sufficient to produce an attack in these asthmatic patients. For example, in the session preceding the appearance of the goldfish, patient M told, tearfully and visibly shaken, about her painful tribulations with her son, a homosexual. This woeful tale induced no asthma, whereas the appearance of the goldfish did. Similar observations were made with other patients. Mere emotional impact was not enough; a quite specific pattern of psychic stimuli was needed, in order to trigger an asthma attack. Clear recognition that the experimental setup was artificial proved powerless to prevent the onset of asthmatic attacks; conscious resolutions not to "give in" to the asthmagenic stimuli were equally futile. These findings made the investigators wonder whether psychic asthma and its spread ought not to be explained in terms of a process of acquired conditioning.

Such a hypothesis would also be able to account for the six failures to obtain a psychogenic response. Four of these patients volunteered the information that the experimental setup did not resemble closely enough the circumstances under which their attacks had "naturally" occurred. A similar explanation could easily be invoked to account for the fifth failure. The learning theorist would say that, with these cases, because of a too great dissimilarity between the "natural" setting and the laboratory situation, stimulus generalization did not take place.

Thus the Dekker and Groen experiment shows that with some subjects psychic asthma attacks can be reliably induced under con-

trolled laboratory conditions and that the apparently effective psychic stimuli (live goldfish in bowl) can be replaced by substitute stimuli (plastic toy goldfish, empty fish bowl) which may prove equally effective in inducing asthmatic attacks.

#### PSYCHOANALYTIC THEORIES OF ASTHMA

As one would expect, psychoanalytic workers have heavily emphasized the psychogenic aspects of asthma. Their observations on asthmatic patients have inspired them to some of their loftiest flights of theorizing.

One prominent psychoanalytic theory stresses the dependency of the asthma patient on the mother or substitute figures, his intense need to maintain a strong maternal bond (French and Alexander, 1941; Weiss, 1941). This theory interprets the asthmatic attack as the symbolic equivalent of a desperate cry for the mother, strangled in the throat. The attack is presumably set off whenever separation anxiety reaches an unbearable pitch. The theory is supported by the observation that many asthmatics appear to be almost constitutionally unable to cry; they suffer from dried-up tear ducts (French, 1939). The shedding of real tears, brought about by the softening influence of psychotherapy, is experienced by these patients as an intense release; it also can terminate an ongoing asthma attack. Into the same context of the "strangled cry for mother" theory, another often noted characteristic of the asthmatic can be easily fitted: his compulsive need to confess, to get things "off his chest," which is interpreted as a conciliatory gesture, as an attempt to abolish a real or fancied estrangement from the vitally needed mother figure. But there are patients, asthmatic children in particular, whose attacks are set off by the threat of too great intimacy with the mother rather than by the immediate danger of her loss (Jessner *et al.*, 1955). It is doubtful whether their spasms and crises of breathlessness still fit the paradigm of the cry for mother.

Some psychoanalysts have linked asthma with conflicts about smells and bodily odors, presumably traceable to early toilet training. Stein and Ottenberg (1958), among others, report some observations to this effect. In a bolder vein, Felix Deutsch connected asthma with fantasies centering around the prenatal state (fantasies about immersion in fluid) and around notions of being impregnated through the lungs. Dunbar (1938) uncovered in her asthmatics a quite different set of respiratory fantasies; she noted an association between asthmatic expiration and aggressive soiling fantasies. It was left to Bacon (1950)

to discover respiratory castration anxiety at the bottom of asthmatic attacks. She suggested that the asthmatic's aggressive impulses provoke fear of retaliatory assaults against his own breathing apparatus and that "the physiological changes which accompany asthma are attempts to ward off the assault."

To the psychoanalyst, these various themes are not necessarily contradictory or mutually exclusive. He likes to think in terms of a multilayered, complexly ramified network of interlacing fantasy themes. To give the reader a notion of this weblike complexity, we reproduce a few excerpts from a case study reported by Rangell (1959, pp. 641-642):

The patient was a young man with a history of almost lifelong asthma. In an analysis lasting many years Rangell uncovered not only the standard psychoanalytic themes, such as desperate crying and passive longing for the mother; it turned out that the asthmatic wheeze was also the nodal point for much more extravagant fantasies. Thus, according to Rangell, the desperate sucking in of air meant at the deepest level to suck in his mother's milk, while his barrel chest represented a container within which he retained milk and love and narcissistic supplies. The lack of free and unhindered communication of maternal love and supplies, which received its most exquisite setback to this particular patient at the time his two-year-younger brother was born, was transformed into his periodic difficulty in exchanging air between his "innards" and the outside world. The frequent flow of mucus represented tears and the narrowed bronchial passages expressed and paralleled his totally inadequate general line of contact with objects and people.

Furthermore, it appeared that fluid or mucus or any extruded liquid was also symbolically equated with blood, which expressed violent, murderous revengeful thoughts (on both an oral and anal-sadistic level) against those at whose hands he had felt rejected and forlorn. Simultaneously, on another (phallic) level, such objections of fluid represented also seminal emissions, which in reality came out in an impotent and ineffective way, diluted and encumbered with numerous conflict-laden (pregenital) wishes. His sick and tender chest cavity also represented an opening into which he would retreat when hurt and in which he periodically lived, when sick, for long periods of time.

The patient himself referred to this lush tropical jungle of fantasies unfurling, under the analyst's magic touch, from his asthmatic symptoms as a "cauldron with a witch's brew," and well he might. Rangell calls the "all-encompassing" asthmatic state "the final common pathway" upon which a "multispiked" psychosomatic process converges—a process "spurred on by energy from multiple and diverse sources rather than concentrated from any one well spring of etiologic energy" (Rangell, 1959, p. 642). It may well take a psychoanalytically



trained or indoctrinated mind to accept these seemingly far-fetched "symbolic equations" at face value. But their curious baroque-ness does not necessarily argue against the psychoanalytic assertions; nor would solid proof of their well-foundedness logically imply that, in each case, these fantasies need to be aired in order to effect a cure.

#### SOME CLINICAL ASTHMA STUDIES

A number of careful asthma studies were carried out by Knapp and Nemetz (1957, 1957a, 1960), two investigators of psychoanalytic persuasion. Their work had the merit of combining a respectable sample size with thorough psychiatric and somatic exploration of individual cases. The authors were cautious in interpreting their findings.

Their sample consisted of 40 patients whose asthma was severe enough to have incapacitated them and required treatment in the year prior to the initiation of the study. In most of these patients, the asthma was chronic and perennial. (Thus very mild cases of asthma were not represented in the sample.)

However, the severity of somatic (pulmonary) incapacity varied considerably within the sample, as did the degree of personality disturbance. The latter ranged all the way from mild neurosis to borderline cases who would occasionally lapse into psychotic-like states without being diagnosable as frankly psychotic. The most frequent diagnosis was "neurotic disorder, unspecified," covering conditions with a mixture of hysterical, obsessive, and depressive features. None of the patients was found to be completely normal even though three cases (three college students) could be described as "borderline normal." This finding jibes with the Dekker *et al.* study, reported above, according to which asthmatics are neurotic.

Knapp and Nemetz were interested in finding out whether there was any relationship between the extent of pulmonary disability and the degree of neuroticism. Hence they had their subjects rated on these two variables by means of four-point scales. The ratings were done by two internists and two psychiatrists, respectively, and appeared to be reasonably reliable. The over-all correlation was extremely high (Pearson  $r = .813$ ,  $p < .0005$ ): the more severe the somatic dysfunction, the more pronounced the neuroticism. The correlation was almost perfect in the "very sick" range of the scales. Only 1 of 9 patients placed medically in group 4 (most severe pulmonary incapacity) was not ranked in the corresponding cell by the psychiatrists. This close parallelism between *degree* of somatic

dysfunction and *degree* of neuroticism is a very striking finding. It also contains a methodological lesson about the desirability not only of specifying the general range of pathological phenomena included in a given study but also of making, wherever feasible, rough quantitative groupings within that range. The very interesting finding of Knapp and Nemetz could only emerge because these authors did not content themselves, as most previous investigators had done, with comparing general qualitative factors of neuroticism and somatic incapacity. (The somatic factor is quantified more easily and more frequently.) This methodological point holds independently of future verification of these particular findings.

The second part of the Knapp and Nemetz study dealt with qualitative clinical findings relative to their asthma patients. It was noted that many of the subjects were suffering also from other psychosomatic or hysterical symptoms. Most frequent were symptoms involving the digestive tract (constipation, diarrhea, abdominal pain, vomiting, and so on), and symptoms affecting the upper part of the breathing apparatus (loss of voice, prolonged nasal colds). Cases of unadulterated asthma were hard to come by. Usually the symptoms would alternate. Often the choice of an alternate symptom seemed to be plausibly related to changes in the patient's life situation. Thus a young woman whose vocational plans were shattered by an early, unexpected pregnancy gave birth to a baby son who was colicky and suffered from diarrhea and projectile vomiting for his first three months. The woman had to relinquish her cultural interests, yet felt wretched and unable to cope with the child. "At that time," she said, "the world looked to me like a huge, dirty diaper." She had always been very sensitive to bad smells, and quite consistently at this period began to suffer from nasal obstructions and related symptoms which led her doctor to diagnose an "allergic" sinus trouble. These symptoms improved and then vanished after the baby's colic had ceased. Somewhat later, under a different set of circumstances, she developed severe asthma attacks.

One of the Knapp and Nemetz findings did not jibe too well with the French and Alexander theory of the "repressed cry." On the basis of that theory, one might expect blatant conflicts about crying to be present among most asthma sufferers. But Knapp and Nemetz noted that such conflicts were inconspicuous among more than half of their subjects. A number of their patients were obviously conflicted about giving vent to any strong emotion, but only a minority appeared to be struggling mainly against crying. Among them was



a 47-year-old man who was hospitalized because of severe asthma and depression and who, at the point of entering the hospital, burst into tears. He said it was the first time he had cried since his mother died from pneumonia when he was five. Weeping, he prophesied that he would not come out of the hospital alive; in spite of treatment with powerful and usually effective drugs, his prophecy came true. He died in the wake of an asthma attack.

While acute conflicts about crying were less prevalent than earlier psychoanalytic writings would lead one to expect, Knapp and Nemetz were struck by the frequency of neurotic moods of sorrow and depression among their asthmatic subjects. Such moods, present in the majority of subjects in the intervals between asthmatic attacks, would tend to get accentuated at times of acute illness. They were called "neurotic" because the feelings of helplessness and gloom were judged to be out of proportion to the somatic distress. Besides, they seemed strongly motivated by unconscious factors. One patient, ordinarily gay and elated, states that when she had asthma she had "no desire to go on." Even "a whiff" made her feel "deflated." She would turn away from her habitual hectic activity, and at the height of her asthma, which had developed originally at her mother's funeral, she would cry, "Mummy, take me with you." The feelings of depressive sadness were mixed, in many patients, with a sense of being doomed or of being marked by a deep and permanent defect. At the ideational level, there were concomitant fantasies of poisonous substances building up within the body, which needed to be expelled by any available bodily route.

In summing up the Knapp and Nemetz findings here reported, we note that persons suffering from moderate to severe asthma are neurotic; that the extent of their neuroticism covaries with the severity of somatic incapacity; that they tend to produce additional or alternate psychosomatic (or hysterical) symptoms, phases of which can often be plausibly related to changes in the life situation; and that they are more likely to suffer from feelings of sadness and discouragement than from actual conflicts about crying (so that some modification of the "repressed cry" theory in the direction of greater comprehensiveness may be called for).

### *A Pluralistic Concept of Etiology*

If we return now to the question of the etiology of psychosomatic disorders, we find that many workers, reviewing the research data



presently available, have revised earlier formulas. The one-sided psychogenic or somatogenic emphases which prevailed during the 1940's are no longer much in vogue. The present trend is to think of psychosomatic syndromes as complexly determined by a multiplicity of conditions, both organic and psychic, with no factor by itself sufficient to "cause" a given disease. This conceptual marriage of heterogeneous psychic and organic factors may be philosophically suspect (see next section), but it seems to reflect best the present state of our empirical knowledge. The following conditions are widely held to determine the onset of psychosomatic disorders:

1. A vulnerable or sensitized organ or organ system ("somatic compliance");
2. The presence of some illness involving the organ system in a relative ("psychic exposure");
3. The symbolic meaning to the patient of a given organ system;
4. Over-all psychic vulnerability ("readiness to regress");
5. The nature and severity of the situational stress.

A number of workers, dissatisfied with psychodynamic formulations, use the general biological concept of "stress" to account for the etiology of psychosomatic conditions. "Stress" is the sum of all forces, whatever their nature, which impinge upon the organism and which are intense enough to cause strain or distortion in the organismic system. The endocrinologist Hans Selye has described a three-stage reaction to organismic stress which he labels the "General Adaptation Syndrome" (G-A-S). The G-A-S is a general, non-specific response of the organism to *any* stressful agent (stressor) of sufficient intensity. The three stages are the *alarm reaction* (initial shock and mobilization of the organism's adaptive mechanisms), the *stage of resistance* (successful adaptation to the stress), followed, if the stress is sustained, by the *stage of exhaustion* (breakdown of adaptation, irreversible structural damage, possible death).<sup>2</sup>

Now Selye has attempted to show that apparently specific disease forms—including various psychosomatic syndromes—can be produced by a wide variety of stressors, both biological and psychological. In this view, it is this broad, non-specific factor of stress which

<sup>2</sup>Selye works with a concept of "adaptation energy," not unlike the psychoanalytic libido concept. He postulates that the individual organism disposes of a limited capital of this adaptation energy which, if spent in the effort to come to terms with stress, leaves the organism biologically destitute, an easy prey to irreversible degeneration and death.

is the primary pathogenic agent, whereas the apparent etiological specificity of certain emotional or somatic factors is said to be an artifact, due to a limited range of observation. Thus hypertension and other psychosomatic conditions are interpreted as partial manifestations of the G-A-S. One drawback of this "non-specificity" formula is that it can neither answer, in its present form, the question of organ choice nor can it simply discard this question as a pseudo-problem.

### *The Body-Mind Problem in Psychosomatic Medicine*

In a new guise the old body-mind problem bedevils psychosomatic medicine. To some extent, the inadequacy of our clinical formulations may simply reflect the philosophical perplexities in this field. Seemingly transparent conceptual formulas become obscure and enigmatic as soon as we probe deeper into their meaning. What do we really mean and imply when we talk of the psychic causation of a somatic event or when we talk in terms of body "acting on" mind? Many workers who use these and similar formulas appear to conceive of body and mind as quasi-autonomous objects, capable of exerting effects on one another (*interaction model*). Such a model, however, leads to manifest philosophical absurdities (Jaspers, 1963, p. 223). Other workers, in an attempt to avoid the philosophical fallacies inherent in the interaction model, espouse a *double aspect* theory according to which physiology and psychology study different aspects of one and the same thing (Alexander, 1950, p. 36). This formula also involves us in philosophical difficulties. Mitscherlich (1953) attempts to solve the problem by diluting the notion of psychosomatic etiology to a concept of *psychosomatic simultaneity* which limits itself to stating purely temporal relationships (simultaneity, antecedent-consequent) between observed bodily and mental events. Dunbar (1959) takes a somewhat different tack. She wants to formulate psychosomatic events in terms of a physicalistic *field concept*. Field theory regards any phenomenon "as an event taking place in a field, an event on which every force in the field may have a bearing, be it active or relatively inert. This field is a complex of forces and conditions which may be plotted by uses of axes and coordinates. Time is regarded as one of the relevant factors" (Dunbar, 1959, p. 4). It is dubious whether Dunbar's field theory amounts to much more than a fanciful way of restating the familiar notion of a multiplicity of determining conditions, which, in the case

of psychosomatic disease, would be partly "organic" and partly "psychic."

More interesting is the position adopted by Merleau-Ponty (1953). According to the French author, the terms "body" and "mind" describe different levels of integration or signification. It is meaningless to talk of causal operations between different planes of integration. The only legitimate meaning to be assigned to the statement that, in a given instance, mind has "acted upon" body is that we are describing human conduct which has been integrated at such a level that it has rational signification and cannot be accounted for in physicalistic or biological terms. Inversely, to say that body has acted on mind can only mean that one deals with less integrated behavior that can be understood without residue in terms of mechanistic or biological notions. Only at these lower levels of integration, which usually reflect deficiency or pathology, do causalistic notions apply.

Merleau-Ponty's perspective implies a timely warning. It cautions us not to overextend the reach of the notion of causality in interpreting human phenomena. Causalistic concepts may be applicable to the description of psychosomatically ill individuals precisely to the extent that their personality and their behavior are disordered, sick. At the level of fully integrated, that is, fully human, conduct, they lose their relevance. Let us illustrate. It has been suggested that the painter El Greco suffered from an anomaly of vision, astigmatism, because of the curious elongation of his painted bodies. Let us assume that El Greco's astigmatism was a proven fact. From this, it "does not follow that the form of the body in his painting . . . admit[s] of a 'physiological explanation'! When irremediable bodily peculiarities are integrated with the whole of our experience, they cease to have the dignity of cause in us. . . . Ultimately, El Greco's supposed visual disorder was conquered by him and so profoundly integrated into his manner of thinking that it appears finally as the necessary expression of his being much more than a peculiarity imposed from the outside" (Merleau-Ponty, 1963, p. 203). El Greco's paintings cannot be explained in physiological terms; the asthmatic's attacks can be so explained, perhaps, to the extent that they are symptomatic of disintegrated behavior. In this perspective, the patient's—and his doctor's—willingness to accept his bronchial sensitivity as a pure fact and to assign causal efficacy to it may denote as much a deficiency in integration as the actual pathological breathing spasm.



The philosophical strictures of Merleau-Ponty and others do not signify that empirical investigations about the correlation between biological and mental events ought to cease forthwith. They only caution us not to inflate unduly the range of relevance of such empirical correlations. They also invite us to remain aware of the philosophical opaqueness inherent in seemingly transparent, "purely empirical" statements about the relationship between given biological and mental events.

### *Treatment*

Psychosomatic disorders are treated either with somatic measures (medication, diet, surgery) or with psychotherapy or with a combination of both. Ideally, both types of therapy ought to be available. The fact that a given condition, say, a peptic ulcer, has been diagnosed as primarily of psychic origin does not necessarily mean that somatic therapy ought to be dispensed with. Besides psychotherapy, the patient may need drugs, a dietary regime, perhaps even surgery. Inversely, an asthma case diagnosed as clearly allergic may yet greatly profit from psychotherapy. Even in cases where it does not markedly alleviate the somatic symptom, psychotherapy may be of help to the patient.

Many psychotherapists are loathe to use the more radical, "uncovering" types of psychotherapy (for example, psychoanalysis) with seriously ill psychosomatic patients. For one thing, they are reluctant to exacerbate the somatic symptoms, which may easily happen in intensive psychotherapy. More importantly, there is a notion abroad, not fully substantiated by the available evidence, that psychosomatic patients are particularly prone to lapse into psychotic states if one "deprives" them of their somatic symptoms. Such symptoms are often held to act as a "protective barrier" against psychotic breakdown. Hence many therapists prefer to use "covering-up" or "sealing-over" techniques which attempt to bury more deeply the repressed, and partly reactivated, emotional conflicts. Yet it is widely held that, in cases where there is a choice and where the risks are not exorbitant, "deep" therapy is the method of choice.

A particular difficulty in psychotherapy with psychosomatics is their often very deeply rooted belief in the purely organic nature of their illness. Another corollary difficulty is that they tend to be overly absorbed with their symptoms. Obviously, such attitudes serve transparent defensive purposes. They help the patient to avoid

the confrontation with his psychological problems. Thus, with many hypertensives, one observes the emergence of a veritable blood-pressure phobia as a result of the diagnostic labeling of the disease. The main life goal of such patients may become to "get the blood pressure down"; everything else becomes unimportant. This morbid focusing is easily abetted by the physician who shares, or appears to share, this narrow somatic concern. In a case of this sort, the patient must be helped to realize that his burdensome disease is not merely an annoying physical accident, purely extrinsic to himself. The hypertensive must be helped to see that his heightened blood pressure may be somehow connected with a constricting life situation which he may not even recognize as such; with an asthmatic, his doctor may cautiously raise the question whether his symptoms of physical asphyxiation may not be his way of reacting to a family situation which he experiences dimly, without clear conscious awareness, as poisonous. The doctor must be very tactful in raising such questions for there are usually excellent reasons for the patient's psychic blindness (for instance, his inability to modify on his own a basically deleterious family situation).

Psychotherapy may also have marked therapeutic effects in patients suffering from chronic organic diseases which are not psychosomatic in the usual sense. Cures which border on the miraculous have been reported by reputable, critically acute workers. A remarkable example is offered by Mitscherlich (1961), who reports the case of a tuberculous young man of 22 who had been shown to have a large pulmonary cavern, typical of tuberculosis, underneath the right clavicle.

Psychoanalytic treatment quickly revealed the presence of what is called, in technical jargon, an inverted Oedipus complex. This means that the patient's relationship with his mother was dominated by intense, hate-filled jealousy and that at the same time his whole character was shaped by a far-reaching identification with her. He idealized the father and made him an object of hero worship. During one analytic hour, the patient started a train of associations about a visit to a museum of natural history where he saw a human fetus for the first time. The sight filled him with revulsion. At this point, Mitscherlich felt that the time was ripe for him to make a far-reaching interpretation. He pointed out to the young man the passive homosexual wishes which seemed to underlie many of his verbal utterances. More specifically, he established a link between the patient's tuber-

cular cavern and unmistakable impregnation fantasies which revolved around the wish to bear his father a child. These are standard fantasies in the book of the psychoanalyst. In the night after this session, the patient vomited and suffered a severe circulatory collapse. Eight days later an X-ray picture showed that the cavern had vanished. After another four weeks, the patient was well enough to be discharged from the clinic.

Mitscherlich does not hide his sense of bemusement in the face of the vanishing tubercular cavern. He writes that his thorough training in physiological thinking made him "almost ashamed of this and similar successful cures." Nevertheless, he is convinced of the causal nexus between his interpretation and the disappearance of the organic lesion. He sees the whole episode as an instance which illustrates "the power of unconscious id-processes in organic diseases." While certainly extraordinary, Mitscherlich's report is not unique. Other investigators have described similar, physiologically scandalous, psychotherapeutic cures of organic diseases.

Good follow-up studies of psychosomatic cases are hard to come by. Stokvis and Welman (1959) evaluated the treatment results with 113 psychosomatic patients falling into various disease categories. These patients had been treated by a combination of somatic and psychotherapeutic methods. The criterion of success was the (in this case) rather odd one of improved social adjustment. Using this criterion, Stokvis and Welman found more than half of the patients markedly improved after therapy. The authors contrasted these findings with their results in a comparable study done with neurotics where the proportion of psychotherapeutic successes turned out to be much lower (23 to 30 per cent markedly improved). Their statistics did not show any significant differences between the results of "deep" uncovering and more superficial supportive therapies. But given the pronounced methodological shortcomings of the Stokvis and Welman study, their results need to be interpreted with great caution.



# 6

## Character Disorders

We now come to an extremely heterogeneous group of disorders which are designated by the more or less overlapping labels of "character neurosis," "character disorder," "behavior disorder," "personality pattern disturbance," "sociopathic reaction," "asymptomatic neurosis," and "psychopathy." The multiplicity of labels reflects the polymorphism of disease pictures which sometimes appear to have only one, negative factor in common: the impossibility of fitting them into the more conventional diagnostic categories.

Just as heterogeneous as the clinical pictures are the classificatory principles by means of which one attempts to constitute subgroupings. Criteria foreign to clinical psychiatry are used as a basis for diagnostic differentiation, for example, moral and judicial criteria. An asymptomatic neurotic who merely annoys those around him is classified as a neurotic character; one who gets in conflict with the law is called a sociopath. The overarching heading of behavior disorder embraces all those who, while free from the usual neurotic and psychotic symptoms, display a neurotic distortion of their whole style of life. Included here are certain asocial or antisocial individuals whose parasitic or criminal way of life clearly reflects strong unconscious conflicts; also included are socially fairly unobtrusive subjects whose neurotic drivenness manifests itself in the exaggeration of character traits which are intrinsically normal. The latter type is illustrated by the eternal blunderer whose every endeavor seems to go awry; the former, by the criminal out of a sense of guilt.

Unsatisfactory as this diagnostic distinction between sociopathic and socially neutral behavior disorders is from a theoretical point of view, it nevertheless makes a certain amount of pragmatic sense. In spite of its crudeness, it seems to highlight important differences in

personality type and psychodynamic constellation. Hence we shall follow here the prevailing nosological schema, and differentiate between *sociopaths* whose offense to their social environment is obvious, and *neurotic characters* in whom the antisocial element, which is never entirely lacking, is relatively subtle and subdued. Among the former we count, besides criminals-out-of-neurosis, sexual perverts, drug addicts, and alcoholics. A special subtype of the morally color-blind *psychopath* is often described here. The social and psychological gravity of particular forms of sociopathy varies enormously, of course, according to individual circumstances and the cultural context, which is most patently true in the case of homosexuality (see below). While in sociopathy the neurotic factor may be more or less inconspicuous, and according to some even totally lacking, it looms obtrusively large in the so-called character neuroses.

### *Character Neurosis*

The present-day psychotherapist sees less and less of the classical, firmly delineated symptom neuroses (hysterias, phobias, obsessional neuroses) which Freud described and which continue to occupy so much place in our textbooks. Instead, he encounters an increasing number of disorders which must be looked upon as neurotic, but which manifest themselves mainly in pathological distortions of patterns of behavior and conduct. The reason for this shift from symptom neurosis to character disorder may be found in an increasing amorphousness of the contemporary personality.

The prerequisite for the development of a classical symptom neurosis is a state of conflict between the ego and the "ego-alien" forces of the superego or id. For such a conflict to take place, the ego, no matter how constricted, must be relatively well structured and delineated; it must be able to experience itself as a unity. The defense measures instituted by the ego to preserve its integrity, in the face of threatened incursions from the psychic nether-sphere, lead to neurotic symptom formation.

If, however, the ego is amorphous and shapeless, it can no longer accomplish the defensive feat of symptom formation. It becomes rent and fragmented, and we are in presence of a character neurosis. Now, earlier concepts of neurotic pathology become problematic—the old model of the conflict between discrete subsystems of the personality no longer applies—and it becomes difficult to discern where the healthy personality leaves off and the neurosis

begins. The ego is at odds with itself, the civil war among the components of the personality having been transformed into an insurrection within one of them.

Hence we are not surprised that the character neurotic does not usually think of himself as sick. He lacks sufficient ego integrity to make such a judgment. It is not he who consciously suffers from his disturbance, but rather those around him. He is wont to ascribe the repeated miscarriage of his enterprises, the abortive quality of his human contacts, to the quirks of fate, and is unsympathetic to the notion of consulting a psychotherapist.

From a somewhat different perspective, one could say that the character neurotic is distinguished by the peculiar thickness and rigidity of a defensive armor which conceals a jelly-like, uncrystallized personality. We know since Freud that even so-called positive character traits can be pressed into the service of defense, and then function as symptoms. We know, for instance, that an exaggerated need for cleanliness can serve simultaneously as a defense against, and a partial expression of, anal smearing tendencies. In character neurosis, neurotic anxiety is not dealt with by symptom formation, but rather by means of a radical alteration of the ego. Thus the symptom of a phobic fear of dirt may be replaced by the character trait of fanatic cleanliness.

The concept of the neurotic character was first worked out by Franz Alexander (1922, 1926). Alexander tried to distinguish between character neurosis and psychopathy by noting that the former is due to a miscarriage of psychic development, understandable in terms of the person's life history, whereas psychopathy, although not unaffected by such historical factors, cannot be adequately explained by them, and hence must be due to genetic or constitutional defects (an explanation in line with traditional European concepts on the hereditary basis of psychopathy). Alexander describes the neurotic character as one "who confuses life and neurosis . . . who lives his neurosis." In contrast to what happens in symptom neuroses, the character neurotic is apt to derive a definitely felt pleasure from the acting out of his impulses, and it is this conscious hedonic gain which endows this form of neurosis with its hold on the personality, a hold almost as tight as that of an addiction.

Following Alexander's leads, Wilhelm Reich (1925) sought to elaborate a systematic typology of the neurotic character. He distinguished five basic character types (the impulsive, compulsive, hysterical, phallic-narcissistic, and masochistic), the genesis of which he



correlated with the vicissitudes of the instinctual history of the individual. Somewhat later, Karen Horney (1937, 1939) developed her schema of the "neurotic personality" in which she focused on certain "overdriven" trends in interpersonal relations. She distinguished three neurotic tendencies in this regard, all characterized by their exaggerated, inflexible quality: "moving toward people," "moving away from people," and "moving against people."

Many investigators believe that superego defect is an important element in character neurosis. The defect is seen as an intermittent functioning of conscience which at one moment is overly tolerant, and the next moment very strict and finicky. Hence the life of the character neurotic is often a chain of more or less minor delinquencies punctuated by painful gestures of self-punishment. Some authors (Brun, Alexander) are of the opinion that the character neurotic's relative freedom from neurotic symptoms is due to the fact that he continually assuages the guilt produced by his acting out by means of self-damaging measures.

### *Sociopathy*

This "acting out" of defective personalities may take a definitely criminal turn and be associated with a moral color blindness so extreme that the observer tends to question the existence of a superego in such cases, or to assume that a rudimentary superego has been forced into unconsciousness *in toto*. In addition, a hereditary-constitutional factor has often been postulated for such cases.

There is a widespread tendency nowadays to view criminality in general as a special case of sociopathy, and hence as a sickness. Now while it is undoubtedly true that many criminals are neurotic or psychotic, it is also true that the mere fact of a violation of the law is hardly a sufficient basis for a diagnosis of psychopathology. Essential to such a diagnosis is a demonstration—independent of the fact of criminal activity—that psychic invalidism is present. And until proof to the contrary, it seems appropriate to hold to the traditional view that criminality is not necessarily congruous with psychopathology.

The extreme type of the sociopath, often designated as "psychopath," with his blithe irresponsibility and apparent freedom from anxiety and guilt, has always aroused a certain horror. This type of person is often found among confidence men, chronic perpetrators

of fraud, forgers, and other practitioners of nonviolent forms of criminality, whose actions cannot be explained in terms of want or need or other rational considerations, and who are characterized by extreme impulsivity and incorrigibility by experience. Because the behavior of the psychopath flouts the usual standards of rational calculation and even of unconscious motivation, the attempt has been made time and again to account for the etiology of psychopathy in terms of extrapsychic, organic factors.

Cleckley (1950) has presented an instructive profile of the psychopath, the major features of which include repeated, apparently unexplainable failure and uncontrolled impulsivity. The psychopath shows a curious tendency of falling into the pitfalls he has dug for others. He is quite capable of giving up a good position on the spur of the moment, or abandoning his family—if he has one—at the drop of a hat, for the most frivolous of reasons.

One might say that he is an adventurer in the service of absurdity who behaves as though he were consciously trying to undermine the moral order of society. In the appearance he presents, and in the havoc he wreaks, he resembles a Dostoyevsky rebel or a Camus hero; yet he is without spiritual depth. His gratuitous acts are not gestures of a mighty defiance, but the outgrowths of shamelessness and lack of restraint. Cleckley mentions the case of a psychopath who, having set out one evening with some companions for a bit of sexual adventure, suddenly, and on the whim of the moment, married the prostitute whom he and his pals had used. Neither then nor afterward did this anti-hero show the slightest trace of embarrassment about his singular step.

The most important feature of the psychopath is his monumental irresponsibility. He knows what the ethical rules are, at least he can repeat them, parrot-like, but they are void of meaning to him. He blandly makes promises which he has no intention of keeping; he signs checks in the full knowledge that they are going to bounce; he gets married, or commits himself to some other major obligation, yet sees himself as unhampered as before. And he does all these things with the mien of entire righteousness, with all the indication of a conscience so clear that other men might envy him for it. No one can so well tell colossal lies while looking the person to whom he is talking straight in the eye. No one wears the mask of normality in so convincing a fashion. He is strikingly cool and sure of himself in situations where others would tremble and sweat with fear. Even when he has talked himself into obvious contradictions, even when

a discovery of his misdeeds is imminent, he retains a superhuman composure. His personality seems to have been especially designed to mock our ideals of stoic self-mastery and unshakable superiority.

The psychopath has a cavalier disregard for the distinction between reality and fantasy. He is almost always an inveterate liar, for whom the distinction between truth and falsity is irrelevant. His lies tend to be art for art's sake, and are often perpetrated without visible advantage to him. He exhibits a childish delight in fabrication, and shows an ingeniousness in the process which would be worthy of a better cause.

Cleckley and other authors emphasize in particular the flaccidity of the psychopath's human relationships, the looseness of his affective ties, which underlies his social affability and his promiscuous sexual behavior. This is rather an advantage than otherwise, since it enables him to heighten the verbal pyrotechnics of his sublime and sentimental professions of love and friendship. And these always find ready victims. Precisely because he is neither engaged nor involved, precisely because he doesn't really mean a word of it, the psychopath is able to play with the cool superiority of a virtuoso on the feelings of the emotionally underprivileged, eliciting from them a response which they would ordinarily be unable to give. It is this which explains his strange fascination for his willing victims, who lend credence to his cries of remorse and promises of reform with a stubborn blindness which again and again cancels out the memory of broken promises and endless misdeeds. The incorrigibility of the psychopath has its counterpart in the inability of his victim to be undeceived by a string of cruelly blighted hopes.

If one attempts to make a phenomenological distinction between the psychopath and the neurotic—including the character neurotic—the decisive criterion turns out to be the freedom from anxiety. The psychopath appears to be remarkably immune to all three modes of anxiety: neurotic id anxiety, normal reality anxiety, and superego anxiety. It is the absence of the last-named which is most disturbing to the clinician. The typical neurotic, and in particular the character neurotic, often shows an off-again on-again superego. The psychopath appears to be devoid of conscience altogether. However, the clinical evidence on this point is not unambiguous. Analytic exploration sometimes unearths nuclear neurotic conflicts attended by suppressed impulse and superego anxiety. Hence the psychopath's superego may be more accurately described as repressed rather than as nonexistent.



It is well known that behavior resembling psychopathy is a regular concomitant of adolescence. A certain emotional and moral coarseness and a chaotic impulsivity are as normal during this period of transition to manhood as Oedipal fantasies during the phallic stage of childhood. They become abnormal only if, being too intense, they cannot be outgrown. Hence we speak of psychopathy only in the case of adolescents whose aggressive pranks exceed the usual, liberally calibrated measure of unscrupulous brutality. While it was long taken for granted that the more extreme forms of adolescent delinquency were largely restricted to youths from a lower-class background—whose misdeeds often contained a strong note of social protest—in recent years a new variety of middle-class and upper-class delinquency has come to the fore, which often vies with the former in blind destructiveness. Many of these delinquents without a cause hover between character neurosis and psychopathy; they attempt to conceal a lack of identity by means of bizarre gestures which often take on a criminal cast. They are to be found among the eternal troublemakers at college who haunt the sleepless nights of deans and other administrators. Blaine and McArthur (1961) have described one subvariety of this type:

In order to prove their manhood, their uniqueness and their conviction, all of which they deeply doubt, they grow beards, scale buildings, get in fights, provoke and defy authorities, or race about on motorcycles. . . . In their assets as well as their liabilities these students seem to suffer an embarrassment of riches. Their aspirations are numerous, conflicting, and evanescent. They believe intellectual accomplishment of the standard sort to be of relatively little value, although they often do well despite distracting symptoms. . . .

Their symptoms appear to be more the function of a disturbed personality development than the expression of specific unconscious conflicts. . . . Typically, the clinical picture is a changing one, reflecting the fluid state of their personality structure. On top of the world one moment, they are furious at it the next, and such swings in mood are often accompanied by corresponding changes in plans, behaviors, and friendships (Blaine and McArthur, 1961, pp. 101-102).

A classical case of this type was described by these two authors in the person of a student who had been nicknamed "The Sultan":

This boy was the product of an old Main Line family. His great-uncle was a notorious Victorian character whose estate is still an architectural wonderment in the region.

The Sultan did well enough in his Harvard courses without ever doing much work, though he always contrived to include one D or E among his B and C grades. He elected only advanced courses in his freshman year.

His expectation about Harvard was, "Harvard men were known to be complete intellectuals and complete dopes." To his amazement, "The ones I've met have been colorful!" He spent most of his time in the Club, where he succeeded in irritating the membership by his ability to luck out in impossible situations at billiards. This was for him more fun than winning by orthodox skill of which he possessed an abundance. At home, the family played "devilish" bridge.

In the science laboratories, he could devise the most ingenious and entertaining experiments with real scientific flair. He never did his assignments. The Sultan was soon on probation for a string of minor breaches of discipline. He became a regular, and rather welcome, visitor to the offices of various deans. He was a big, warm fellow whose boyish appeal reached the paternalistic side of the administrators' hearts. Unhappily, none felt moved to abrogate the rules. Unhappily, too, the Sultan displayed a massive dose of what one psychiatrist dubbed "traumatophilia" (a liking for hard knocks). It is not clear that he really wanted the warm-hearted reaction he evoked from all. At one point he was able to say that he realized that he had an irrational feeling that study was degrading. To open a book was "cheating." Also, he knew that he "wanted to be scared" and that we "wouldn't oblige."

He came to the psychiatric service by a fluke; ordinarily, this sort of boy does not come in to us unless sent. We were also warmly on his side but, loath to alter reality until it is no longer recognizable, we refused to keep the Sultan in good standing by asking for special dispensations on his behalf. His creative genius was unexcelled. When not driving his motorcycle into a Harvard Square store, he was organizing an expedition to climb the Memorial Hall tower. He was intoxicated on most week ends and one Monday morning appeared in the waiting room, drooped, teeth loosened, eyes black, head aching. Sympathetic inquiry revealed that he had attempted to fly! Since he lived in a second floor room and his flight was powered only by whisky, the results were pathetic to see.

And so it went. At one point, he was going to enter the service before being fired; somehow that fell through. At another, he managed to get his parents interested enough to come to Cambridge to negotiate his case, but by then it was much too late.

He was dismissed from college. Since leaving, the Sultan has held a succession of jobs, briefly and spectacularly. As a freight clerk he moved pianos onto freight cars unaided; then he became vice-president of a sales agency. Then he decided to return to another school, where he made a straight A record for a term and quit while he was ahead.

In the end, he settled in Hollywood, living on an allowance, going to studio parties, and doing bit parts off and on. He is universally acknowledged—even in the gossip columns—to be a genius at gin rummy.

He applies for readmission to Harvard semiannually but, on being told the procedure to follow, never quite follows it.

Early in this story, the Sultan received psychological testing. His Rorschach was clearly neurotic. Very much in touch with reality, he had decided not to face it. He was a fine instance of someone impinged



on the first horn of Erikson's dilemma: avoiding the "autocracy of conscience" by submitting to the "anarchy of impulse." His anarchic impulses were his retreat from the unhappy features of the world of everyday living. Why he needed such a dodge became clear at once when he began his Thematic Apperception Test. To the initial picture, a child looking sadly at a violin, he said assuredly, "But this is purely obvious! The child made the mistake of showing interest in a violin and lo and behold he gets stuck with a violin. At present he's trying to think of something like putting pennies in the violin and seeing how they'll distort the noise." We could call that "creative resistance." Later, in the same TAT story, the hero's fate is described. "All through his life, he's going to be pushed. By this time his family has decided he's a potential genius. He may be somewhat proud of that." The Sultan was, in objective fact, a genius. Like so many of these students with character disorders, he suffered from a plethora of assets which he never geared to productive use (Blaine and McArthur, 1961, pp. 102-104).

This case was particularly instructive in that a later TAT test clearly revealed the presence of a deeply buried neurotic castration conflict which undoubtedly wrought its dynamic effects behind the façade of cavalier nonchalance. This seems to confirm the previously advanced notion that neurotic conflicts are often not found in these cases for the simple reason that the therapist has not dug deep enough.

Individuals of this type are wont to look upon the psychiatrist as an object of manipulation, which they try to use in order to mold reality closer to the heart's desire. What results is a double comedy where a man who does not consider himself sick and believes that he is merely play-acting the sick role, strives to exploit the supposed naïveté of the psychiatrist who considers him to be sick, but who is unable to convey this fact, and hence frequently proceeds, in the face of contrary knowledge, "as though the patient were healthy." Otherwise he risks heightening the unreality of the patient's world by seeming to play along with the attempt at manipulation.

#### THE ETIOLOGY OF PSYCHOPATHIC BEHAVIOR

For a long time, it was customary to attribute psychopathy chiefly to hereditary and constitutional factors. Even today many investigators speak of constitutional psychopathy and adhere to the view that psychopathy, in contrast to neurosis, cannot be understood in terms of the life history.

In recent years, however, an increasing number of psychoanalytically oriented workers have inclined toward the view that the decisive causal factor in psychopathy is psychological: a miscarriage



of the early stages of socialization and superego formation. According to this view, the absence or remoteness of appropriate models or mentors is decisive in the developmental history of the psychopath. This lack closes off direct identification as a means of learning acceptable social behavior. The persons in charge of the child—parents or their surrogates—are either psychologically distant or too defective in their personality to permit the formation of durable libidinal ties, which is the prerequisite of socialization. The process of socialization requires the renunciation of powerful impulses, and this sacrifice is possible only if compensations in the form of parental love and encouragement are forthcoming. If the supplies of affection fall below a critical minimum, the whole effort is no longer worthwhile, and the person goes his lonely way into asociality.

One has tried to validate hypotheses of this kind by showing that orphans reared in institutions exhibit more psychopathy than those brought up by foster parents. But even though such observations may be correct, it is equally true that a number of psychopaths come from seemingly normal families and have grown up among socially well-adjusted siblings. The question is whether deeper probing may not reveal a more than usual degree of family strife behind the normal façade. In some of these "good" families, at least, one gets the impression that the black sheep psychopath is less an alien intruder than a predetermined scapegoat who, for a variety of reasons, assembles in his person and makes visible the hidden blemishes of a corroded family situation. We can perhaps best summarize these points by noting that the psychogenic thesis in its above form, in spite of a certain plausibility, is really too general and diffuse to serve as an explanation of the psychopath's specific etiology.

A somatogenic thesis which de-emphasizes hereditary-constitutional taints is based on the observation that inflammation of the brain (encephalitis) often produces psychopathic impulsiveness in previously asymptomatic persons. A larger than average number of abnormal encephalographs have been reported in clinical investigations of groups of psychopaths; one has interpreted these findings as confirming organic theses which postulate a close causal nexus between brain damage and psychopathy. However, for each study with positive findings another one with negative results can be found so that the evidence remains, at best, inconclusive.

In view of the unsatisfactory state of our present knowledge, it is hardly surprising that many investigators espouse vague eclectic

theories which derive psychopathy from a minimally articulated interaction of genetic predisposition and organic or psychic trauma.

### PSYCHOTHERAPY

While there is considerable disagreement about the prognosis for psychiatric treatment in the case of the character neurotic, a general consensus prevails with regard to the psychopath: he is considered to be a particularly thankless object of psychotherapy.

In general, it can be said that the more pronounced the neurotic element of the disorder, the better the prognosis for psychotherapy. The usual therapeutic procedure fails to take hold in the case of the true psychopath because he is unable or unwilling to become emotionally involved with the therapist, to grant him admittance into his insulated world. Group therapy is somewhat more promising, in particular for youthful psychopaths who sometimes respond well to integration in boys' towns or therapeutic communities. In the relatively stable environment of a simply structured community which places an optimal number of demands on its members, the shriveled rudiments of social participation can undergo a belated maturation. The pressure of the peer group offers an important lever for social adaptation, and so does the imposed discipline of productive work (work therapy).

An additional reason for the frequent failure of individual therapy lies in the fact that the psychopath does not accept the benevolence of the therapist at face value; he interprets it as a sign of weakness. But if the therapist acts tough and unsentimental, he is likely to be perceived as just another hated authority. It requires a great deal of flexibility to find the proper mixture of benevolence and firmness.

In his extreme form, the psychopath is a subject of great scandal for the meliorist who believes in the omnipotence of love plus technical competence, and whose world view does not admit the concept of radical evil. Thus the psychopath injects a truly demonic element into the narrow world of the inveterate rationalist. The psychopath is discomfiting because he escapes the usual categories of psychological understanding; he mocks all attempts to reduce him to a psychodynamic formula. His profound, seemingly perverse irrationality, often coupled with remarkable intellectual gifts and a lack of delusions or other psychiatric symptoms, is in many respects more uncanny than the incoherence of the psychotic whose delusional world we manage to enter, sometimes, through an effort



of the imagination. It is the gratuitousness of the psychopathic act which so scandalizes the reasonable observer. Even the most judicious use of the concept of insanity fails to come to terms with the phenomenon of the psychopath who, more than ever, is an irruption of the demonic in a society, the energy of which is bent, to a large extent, upon the rationalization of the unpredictable and mysterious.

### *Homosexuality*

Of the sexual deviations which in the usual diagnostic schema are subsumed under the behavior disorders or sociopathies, homosexuality is the most important. It is undoubtedly the most widespread of the sexual abnormalities. If we are to believe Kinsey's figures, sporadic homosexual acts are in fact committed by more than one-third of adult men in this country.<sup>1</sup> Kinsey (1948) and Ford and Beach (1951), among others, conclude from these figures that only on the basis of obsolete, patently mistaken prejudices does society continue to brand homosexuality as pathological or perverted. These authors, supporting their theses also by anthropological data, look upon homosexual acts as falling well within the normal range of sexual behavior. However, their point of view is by no means uncontested. Thus, most psychoanalytically oriented workers hold that *adult* homosexuality is, under almost all circumstances, a pathological sexual aberration, no matter what its incidence. This is also the thesis adopted by the up-to-now most thorough psychoanalytic investigation of homosexuality, that of Bieber and his collaborators (Bieber *et al.*, 1962).

We shall return later to this controversy, but for the moment let us look at some of Kinsey's figures, from which the homosexual experiments of adolescence, considered to be quasi-universal, are excluded. As far as adult American men are concerned, Kinsey's statistics suggest that 37 per cent of them have had at least some overt homosexual experience to the point of orgasm at some time between adolescence and old age. An appreciable 30 per cent of all males have at least incidental homosexual experience or reactions for a period of three years or more between the ages of 16 and 55. And between the same age limits, the likewise considerable figure of 8 per cent of American men have been *exclusively* homosexual for three years or more.

<sup>1</sup> Kinsey's incidence figures for female homosexuality (lesbianism) are considerably lower.



Kinsey's startling figures have been attacked repeatedly as unreliable. In particular, he has been taken to task for a poor sampling method. But the admittedly skimpy and fragmentary statistics on homosexuality from other sources seem to confirm at least the order of magnitude of Kinsey's figures which, at any rate, are the best we have at present. Kinsey himself took the view that if his figures erred at all, it was in the direction of understatement.

Kinsey's study has also been attacked from a moral point of view. It has brought him the reputation of a corrupter of youth, a latter-day Socrates. Thus the psychoanalyst Bergler has accused Kinsey of having contributed, by his publications, to an increase in homosexuality. According to Bergler, Kinsey is responsible for the creation of a new category of deviants, namely, "statistically induced" homosexuals, who have been prompted to engage in homosexual experiments as a result of reading Kinsey. It would seem, though, that Bergler exaggerates the corrupting power of statistical tables. Kinsey's purpose was certainly neither polemical nor antimoral, and one cannot undo the results of his investigations by means of moralistic arguments. One would blush to mention such truisms were it not for the fact that they are ignored time and again.

From a *theoretical* point of view, the problem of homosexuality is of special interest as a sort of nodal point where the perspectives of various sciences of man meet; it is a problem on which the sociologist, the anthropologist, and the biologist demand as much to be heard as the psychologist or psychiatrist.

For the anthropologist and sociologist, it is clear that social institutions and the prevailing mores exert a decisive influence on the incidence of overt homosexuality. It has long been known that different cultures take widely differing views about the "naturalness" of homosexual behavior. Some cultures institutionalize homosexuality either in their religions (for example, the *shamans* of Northern Siberia or Borneo) or in their social structures (the *berdache* of American Indian tribes, or the homosexual youth of classic Greek antiquity).

We know that the odium attached to homosexual relations varies from society to society, and from era to era. Ethnologists like Westermarck take the view that at least sporadic homosexuality occurs in all the races of man. According to Ford and Beach's anthropological data "100 per cent of the males in certain societies engage in homo-

sexual as well as heterosexual alliances" (Quoted by Bieber, 1962, p. 16.). Not only in primitive societies, but also in such developed civilizations as those of China and Japan, love of one's own sex was free of public opprobrium until the influence of the Christian West was felt. Cory suggests that "the Chinese people considered homosexuality an effective means of controlling the growth of the population," and he adds: "It is from China that one traveller returned with the famous remark that he had never heard a Chinese say that homosexuality was bad, except for the eyes" (Cory, 1960, p. 16).

In the Western world, homosexuality has been stigmatized consistently by the Christian tradition with its emphasis on reproduction as the sole legitimate function of the sexual act. In the Europe of the Middle Ages, clerical and secular authority equated "unnatural love" with witchcraft and heresy, punishing it with extreme severity, sometimes by burning at the stake. Only in modern times has Christian Europe evinced more tolerance toward homosexuality, which in France was omitted for the first time from the list of criminal offenses in the Code Napoleon. Very recently (1957), the so-called Wolfenden report in Great Britain suggested that freely engaged-in, private homosexual acts between adults no longer be considered punishable offenses in that country.

Whereas the sociologist and anthropologist inquire into the social determinants of homosexual behavior, the biologist attempts to trace its possible genetic roots. The question to what extent biological and hereditary factors predispose to homosexuality comes up again and again, despite the tendency of a great number of contemporary American psychopathologists to look upon homosexuality as a purely psychological disorder which, theoretically at least, can be cured by means of psychotherapy.

Before we come to grips with the various theories on homosexuality, it may be well to deal with some of the myths which becloud the theoretical issues.

#### SOME MYTHS ABOUT HOMOSEXUALITY

A very popular myth asserts that it is easy for the observer to identify homosexuals; they are believed to betray themselves by feminine traits and behavior, by a high-pitched, melodiously inflected voice, a swishing or mincing walk, exaggerated estheticism, and fastidiousness of dress. In actual fact, only a minority of homosexuals display these characteristics, namely, those who choose to display

them for deeply rooted exhibitionistic reasons. Most homosexuals are unobtrusive, not identifiable as such to the naked eye.

A related myth is that homosexuals are to be found chiefly in occupations defined by the culture as feminine, for example, dress designing, hair dressing, ballet, and other entertainment fields. While it is true that these occupations do, indeed, attract homosexuals, it is equally true that the latter are to be found in the most varied walks of life, and often enough in those we tend to think of as particularly masculine, such as professional athletics and the military life.

Those who are willing to concede that homosexuality is not easily recognized by the layman often hold that the expert, and especially the psychologist with his arsenal of tests, can reliably distinguish homosexuals from normals. And, to be sure, a good many clinicians flatter themselves with possessing such diagnostic perspicacity. Publishing lists of homosexual signs in Rorschach or other test protocols has long been a favorite sport of clinical psychologists. However, Evelyn Hooker (1958) has shown that even outstanding clinicians find it impossible to sort out homosexual from heterosexual Rorschach records if the sample of homosexuals is well chosen, that is, if it is drawn from homosexual groups which do not usually come to the professional attention of the clinician. Relatively easy to spot are only the records of homosexuals who are eager to be identified as such or whose sexual tastes are closely interwoven with the texture of neurotic or psychotic personality deformations—in other words, the very people who constitute the bulk of the clinic populations and whose test reactions furnished the homosexual diagnostic signs in the first place! It may be noted parenthetically that, even if strong homoerotic impulses have been correctly detected in a test protocol, it is often difficult to decide whether these impulses remain at the level of fantasy or are expressed in actual sex behavior.

Another widespread popular belief holds that overt homosexuality tends to be much more frequent in the upper strata of society than in the lower. Kinsey's data belie this notion; they show the incidence of overt homosexuality to be higher in the group which do not go beyond high school than in the college group. A breakdown by occupational status had parallel results.

Still another myth asserts that there exists a clear division between active and passive homosexuals, between "fairies" who play the feminine submissive role in the sexual partnership and those virile



types who invariably assume the masculine active role. The truth of the matter is that this distinction is, at best, a relative one; there is no fixed sexual role for the homosexual (as little as there is for the heterosexual). The same individual may assume an active or passive role depending on who his partner is, or even with the same partner, in line with the vicissitudes and vagaries of a relationship which, like all human relationships of a certain intensity, is apt to undergo all sorts of fluctuations and reversals. The very notions of "active" and "passive" in regard to sexuality are ambiguous and potentially misleading.

In the preceding section, we have challenged some of the more peripheral myths clustering around the subject of homosexuality. But since the Kinsey report, it has become increasingly clear that the concept of the "homosexual" itself stands in need of revision. We usually talk of the homosexual and the heterosexual as of sharply opposed polarities, as though we were dealing with discrete, mutually exclusive categories. But the most essential lesson to be learned from Kinsey's figures is just the impossibility of making such a discrete distinction. Kinsey's data show that heterosexuality and homosexuality, identifiable though they may be in the extremes, overlap in a band of bisexuality which is much wider than had previously been suspected. Not only is this the case for bisexuality at the latent psychic level which Freud had postulated; it is also the case at the level of manifest desire and overt activity. Kinsey found a relatively rare 4 per cent of the male population to be exclusively homosexual after adolescence. However, about one-third (30 per cent) of the male population have at least incidental homosexual experience or reactions over at least a three-year period between the ages of 16 and 55; almost a fifth (18 per cent) of American men have at least as much of the homosexual as of the heterosexual in their histories for at least three years between the ages of 16 and 55. Finally, one-half of the male population is free from conscious homosexual impulses and activities after the onset of adolescence.

Such findings led Kinsey to renounce using the discrete categories of heterosexuality and homosexuality, and to adopt instead the notion of a "heterosexual-homosexual balance" which for each individual tried to estimate the relative proportions of these elements in his sexual make-up. Seven scale points were used, the two extremes, zero and six, being the pure heterosexual and the pure homosexual types. It is clear from the figures quoted above that the frequency distribution of heterosexual-homosexual ratings does not follow

the normal or bell curve pattern, but is heavily skewed in the direction of heterosexuality. Nevertheless, the fact that nearly half (46 per cent) of the male population is "bisexual" to a varying degree, reacting sexually to men as well as to women during a significant period of adult life, is astonishing. (These are the subjects who rate from "one" to "five" on Kinsey's scale.)

These figures can be variously interpreted. Kinsey and other investigators conclude that polymorphous sexuality is the (ideal) norm rather than a pathological variant of male sexual behavior. They do not look upon homosexual activity as abnormal, and voice the opinion that the asymmetrical distribution of actual incidence figures reflects, in the main, the distorting pressures of social opprobrium and censure. The majority of psychoanalysts, on the other hand, are unimpressed, and stick to their classical position that adult homosexuality is pathologic under all circumstances, even when it occurs as an admixture to heterosexual behavior. They contend that Kinsey's incidence figures mirror social and individual pathology, for, to their way of thinking, cut-off points on statistical curves cannot convincingly establish the criteria of health and pathology.

### *The Etiology of Homosexuality*

Pre-Freudian psychiatry conceived of homosexuality primarily as an organic disease due to congenital defects. Experiential (developmental) factors, if considered at all, were assigned a subordinate role. Krafft-Ebing typified this line of thought when he attributed homosexuality to "hereditary neuropathic degeneration," without demonstrable pathology in the central nervous system. Lombroso was of the opinion that homosexuality, like criminality, resulted from the persistence of an atavistic sexual instinct. Jaspers classified homosexuality into three categories: accidental, psychogenic, and constitutional. He thought that constitutional homosexuality must be rooted in the "deepest" layers of the soma—in the central nervous system or in the germ plasm itself. Like other observers, Jaspers was struck by the "curious sensitivity" and the esthetic predilections of the homosexual, by his habit of seeing "the whole world bathed in a different light." For a time, hormonal theories of homosexuality were in vogue. The disorder was ascribed to disturbance in the endocrine balance. This seductive theory was shown to be false by the repeated demonstration that artificial interference with this balance, through the administration of sex hormones, does not reverse the



direction of sexual orientation. It merely energizes the previous sexual pattern, whatever it was. Thus, the administration of male hormones to a (supposedly feminine) homosexual will not deflect his urges from men toward women. It will only intensify the power of his homosexual drives. Nor will castration change the orientation of well-channeled homo- or heterosexual interests.

#### THE BIOLOGICAL THEORY OF "INTERSEX"

Of the biological theories of homosexuality, the most interesting and the most widely discussed was Goldschmidt's (1916) theory of "intersex." Goldschmidt held, in essence, that accidental mix-ups of chromosome sets produced what he called transformation-males or -females. In their general morphology, these variants have the characteristics of one sex, but their specific sexual apparatus is that of the other. Goldschmidt carried out his investigations on insects and did, in fact, demonstrate the occurrence of intersexual individuals among his gypsy moths which were intermediate between male and female in the manner postulated. Without much hesitation, he generalized his findings to human beings. But as Kinsey and others have pointed out, there is really no adequate basis for such an extrapolation. An ingenious attempt to verify Goldschmidt's conclusions was undertaken by Lang, who argued that if some male homosexuals are actually variant-males, then among their siblings there should be more men than women, the ratio of males to females being constant in the general population (100 males for each 105 females). Lang's statistical investigations initially seemed to confirm Goldschmidt's views but in the end remained tantalizingly inconclusive.

The theory of intersex has fallen into disrepute, along with other biological theories of homosexuality. Recent observations on the dispersion of bisexual behavior in general have discredited simplistic, one-sided theories. The opinion that biological factors may play a determining role in the etiology of homosexuality persists in many quarters, but those theories which stress the causative significance of experiential factors are clearly predominant today.

#### PSYCHOANALYTIC THEORIES OF HOMOSEXUALITY

From a psychopathological point of view, homosexuality is less a syndrome like hysteria or obsessional neurosis than a symptom or cluster of symptoms which may occur in the most varied of pathological contexts. Homosexual behavior may be woven into the texture of a symptom neurosis, a character neurosis, a psychopathic disorder,



or a psychosis. Some investigators (Kinsey, Hooker, Beach, and Ford) even claim that it can occur in the context of an essentially healthy personality. In the discussion which follows, it may be well to keep in mind that the psychopathological weight to be assigned to homosexual behavior may vary enormously from case to case, and that, according to some, such behavior is not even a reliable indicator of the presence of psychic pathology.

Among theorists emphasizing the psychic determinants of homosexuality, the psychoanalysts are the most articulate. Freud thought of homosexuality and other sexual deviations as a sign of retarded psychic development, and in this and other respects assimilated it to the neuroses and the psychoses. His theory of bisexuality postulated that undifferentiated polymorphous sexuality is a normal transitional phase in the maturation of the sexual instinct. Young children and primitives are said to be indiscriminate in the choice of sexual objects. The homosexual's difficulty arises from the fact that his development is arrested at this undifferentiated level of object choice or that the differentiation itself proceeds in the wrong direction.

According to Freud, the genesis of homosexuality, like that of the psychoneuroses, may be traced back to difficulties associated with the Oedipal phase of development, in particular, to especially severe castration anxiety due to intense sexual rivalry with the father. The special twist which this anxiety takes is said to be due to the future homosexual's traumatic delusion, during this critical stage, that the genital of his mother or sister is in reality a castrated male organ. This anxiety-ridden misperception lends "objective" support to his apprehensions. It is a widely held notion that for the homosexual the female genital is a phobic object. The homosexual himself, according to psychoanalytic theory, interprets his revulsion at the sight of the female organ in an esthetic fashion. But in this, he is mistaken; in reality, the female genital disgusts him because of its evocative power—because it reminds him, brutally, of the ever-present threat of emasculation.

Another component in the homosexual's make-up which psychoanalysis stresses is his strong narcissism. The homosexual is said to be stuck at the level of autoerotic object-choice. It is a frequently made observation that the homosexual chooses love partners who in their physical and psychic features are strikingly similar to him or to his idealized self-image. He loves in others primarily the reflection of himself. His personality is too constricted to reach out for the opposite pole of female sexuality.

Rado (1940) and some of the neoanalysts have discarded the Freudian notion of bisexuality and stress primarily the phobic element in homosexuality. Thus Rado attributes homosexuality to "hidden but incapacitating fears of the opposite sex," leading to a pathological restriction of object-choice. He believes that the homosexual adaptation "through symbolic processes is in fantasy a heterosexual one . . . in which problems of rivalry with isophilic partners who represent father are solved." Kardiner (1949), taking a sociological-anthropological slant, put a major emphasis on the element of social control. He believed that in order to prevent sexual irresponsibility in the immature, it is necessary to institute social efforts which "terrorize the child out of its sexual interests, so that the sexual drive is deflected into channels other than heterosexual." If the controls are made too tight for an individual predisposed to anxiety, the homosexual orientation of drives may "set," or become permanent.

Silverberg (1952) reinstated the old distinction between more or less peripheral homosexual *behavior* and genuine or neurotic homosexuality. The former he interpreted as an expression of defiance of constituted authority, but also, and more importantly, as an attempt to replace an unsatisfactory mother by the father as a source of emotional succorance. He felt that with American men the anxious quest for a nurturant father figure may account for the high incidence of sporadic homosexuality noted by Kinsey and other observers. Silverberg viewed "true" homosexuality as having much deeper neurotic roots in the infantile personality. He regarded it basically as an unconscious maneuver, the gist of which is to bind the father symbolically in the homosexual relationship, and thereby to make him unavailable to the mother.

There is no end to such psychoanalytic constructions. They are hard to disprove empirically, and equally hard to prove. The majority of them agree only in the conclusion that adult homosexuality is pathologic. They assign differing weights to constitutional and experiential factors, but are in essential accord in maintaining that the experiential determinants are mainly rooted in childhood and are primarily related to the nuclear family.

#### FAMILY PATTERNS WHICH PREDISPOSE TO HOMOSEXUALITY

Important efforts have been directed toward isolating basic family constellations which predispose to homosexuality in the child. While it would be unrealistic to expect one pattern of family interaction to



account for all cases of emergent homosexuality, one pattern has been described frequently enough to deserve special attention. This is the classic triangular configuration, most recently and succinctly, if not most elegantly, described by Bieber and his collaborators (1962). These authors describe as optimal for the production of homosexuality a family constellation "where the mother is CBI (Close-Binding-Intimate) and is dominant and minimizing toward a husband who is a detached father, particularly a hostile-detached one" (Bieber, p. 172). A son tied by a strong silver cord to a hysterically inclined, possessive, and domineering mother; a family triangle distorted by the fact that the paternal position is psychologically only partly occupied—such is the potent combination of features which, though it need not inescapably lead to homosexuality, is very often found to be an antecedent setting for it. The dynamic quest for intimacy with the psychologically remote, and magically powerful, father figure is remarkably evident in many instances of inveterate homosexuality. (One of Bieber's more interesting findings is that a supportive, affectionate father is an almost certain guarantee against the development of homosexual pathology in the son. Far from defaulting his paternal role out of submissiveness to his wife, such a father will intercede between the son and the hysteroid mother, thus protecting the boy from overattachment and emasculation.)

Bieber *et al.* give the case history of a homosexual patient who spent most of his life in the clutches of a seductive and hysteroid mother:

The patient entered psychoanalysis with a female analyst at age thirty-five, after he was retired from the army on neuropsychiatric grounds toward the end of World War II. His homosexual practices began with mutual masturbation at the age of seventeen with a partner of the same age. During the following years he participated in homoerotic activities of all types, with mutual fellatio predominating. The patient went through long periods without homosexual activity and during the war he was sexually inactive. He achieved a distinguished war record. The patient described his mother as an extremely nervous woman who was overprotective, seductive, and close-binding-intimate. "She is a bundle of nerves and terror. . . . She considers my father a villain—she has accused him of playing God, being unhelpful, and all sorts of things."

When the patient was four years old his parents quarreled bitterly; he did not know why. At that time the mother stated that she would raise the child without the father's help. The father, indeed, remained an outsider. He was of German extraction and this created difficulties for his son during World War I. He was frequently chased off the street by



other children and called "Heinie," whereupon his mother would say, "Never mind, come into the house with me—I will teach you how to knit." He learned to knit well.

Between the ages of four and seven the patient had a minor intestinal condition and his mother kept him in bed most of the time. Her daily ritual was to rub his back, then pat his buttocks and kiss them. When he was seven years old he had an erection while his mother was thus engaged. He was completely terrified and was desperately frightened that she would notice it. His immediate thoughts were that he must hide it from her and that it must never happen again. He referred to "the back-rub business" many times during the analysis, and stated that it had made him so afraid of sexual activity that he had divided himself in half—from the waist down he was numb.

The patient had no playmates during childhood although the family lived in the same house for a long time. Beginning at an early age and continuing through his later life, his mother would criticize him as soon as he "opened up" with others. She arranged to cut him off from any outside relationships. "It was as if she demanded that I give her all my attention. She criticized my friends and did it so nicely that it hurt more."

The mother was a "vitamin-conscious" hypochondriac who expressed a great deal of concern for the patient's health. She created in her son a marked tendency to worry excessively about health. At the ages of eight and nine he had asthma. "My asthma is the story of my attachment and dependency on my mother." Along with her emphasis on nutrition she considered any waste of food a cardinal sin. All leftovers were saved. Although the father earned a fair living, the mother behaved as though they were very poor people, and the patient resented the feeling of great poverty this gave him.

The patient detailed how his mother constantly "babied" him and continued to do so into his adult life. He frequently received gifts from her "on the sly." During his analysis he went to a store to buy her a birthday present. While there, he had an attack of numbness, feelings of chest congestion, and believed that his eyesight had suddenly become defective. He never overcame intense feelings of anxiety associated with his mother; even during his adult years, a call or visit from her made him feel "morbid."

The patient was an outstandingly handsome man, of imposing height and muscular development. When on vacation he would avoid homosexual gathering places; instead, he would go to Miami where he enjoyed exposing his magnificent physique on the beach for the ladies to admire. He attempted heterosexual intercourse for the first time at age twenty-eight, and failed. He lived with a woman for about a year although no sexual relationship existed between them. He attempted intercourse with another woman and failed again. Following his three failures he gave up heterosexuality entirely.

The patient maintained occasional contact with his psychoanalyst after his analysis was terminated. At the last contact he had given up homo-

sexual activities, did not become heterosexual, and remained sexually inactive (Bieber, pp. 58-60).

In this and similar cases, the father remains a remote, aloof, shadowy figure. In another case history, the father is described as someone who behaved at home "as if he were a boarder," occupying his own room and keeping to it. An obtrusive childhood memory of still another patient involved the father sneaking out of the house, behind the mother's back, in order to keep a poker date. Of the total sample of 106 fathers of homosexuals in Bieber's psychoanalytic study, 79 were classified as detached (44 of these 79 were openly hostile and 18 were indifferent in their detachment; 14 were ambivalent and 3 were dominating-exploitative). Although a few of the nondetached fathers were extremely pathogenic, the father's involvement with the son, no matter how ambivalent or conflicted, seemed in general to militate against an extreme commitment to homosexuality. None of Bieber's group of homosexuals was found to have a father who was warmly related to him (Bieber, pp. 290-291).

In concluding this section, the author wants to caution the reader against the danger of oversystematization. It is true that Bieber and other investigators have extracted a modal triangular pattern from the case histories of a great number of homosexual patients. But this should not blind us to the fact that a bewildering variety of other family constellations appear among the antecedents of homosexuals. The most superficial perusal of a number of case histories will enlighten us on this point. As we have seen before, psychopathological phenomena resist neat ordering and categorization. The best that can be hoped for at present is to isolate certain dynamic clusters or constellations which account for a significant number of the class of phenomena under scrutiny.

#### EXISTENTIALIST VIEWS OF HOMOSEXUALITY

Attempts have also been made to give a nonanalytic psychological interpretation to homosexuality. Thus, the so-called anthropological school in Europe (von Gebattel, E. Straus, H. Kunz) sees the conscious denial and desecration of generally accepted positive values as the decisive element in sexual perversion. "It is precisely the reversal of normal love, the flagrant violation of erotic sense, which constitutes the exciting content of the perverse act" (von Gebattel, 1932).

Straus illustrates the point by reference to coprophilia (inordinate interest in feces): "The coprophile doesn't really enjoy his contact



with excrement. Instead, the sense of his behavior arises for him out of the significance of dirtying, of desecration, and of self-destruction. Blow-flies seeking their nourishment in excrement are not coprophiles nor are chickens scratching about in manure, nor a sick person, who needs the Diuretine extracted from guano. . . . A child, inasmuch as he hasn't yet comprehended the meaning of putrefaction and therefore feels no disgust, can play harmlessly with excrement. The coprophile, on the other hand, draws the meaning of his experience exactly out of his union with the Disgusting. This kind of reactive element belongs to coprophilia as to all perversions, which . . . just because of this reactive, distorting character can never have been original impulse objectives" (Straus, 1930, pp. 113 ff.). The specific hedonic gain in perversion is, according to this view, a product of the triumphant contamination and desecration of traditional, piously consecrated values.

Among the existential analysts, it has been Boss (1952) in particular who has sought to give a unique interpretation to the sexual perversions. He bases his analysis on a special description of normal love. This, he asserts, strives to create a double-sexed anthropos, a hermaphroditic homo androgynous, by means of the loving union of man and woman. In order to accomplish this, the partners must be mature human beings, free of anxiety, able to give of themselves, and to realize the ideal form of love in the sensual-corporal as well as in the intellectual-spiritual sphere. Those, then, who defect to deviant forms of love are, according to Boss, shriveled personalities who are trapped in a narrow and tyrannical world, and yet strive to attain, in the face of great outer and inner obstacles, as much as possible of the full reality of love, in the only way open to them: the deviant, norm-defying sexual act. In other words, sexual deviations are interpreted as stunted, mutilated forms of love, as tortured attempts to come to terms with inborn or acquired personality defects which forbid the realization of the ideal man-woman union. Boss believes that even these deviant erotic configurations are illuminated by a glimmer of the full-fledged reality of Loving Existence, and he adduces Freud's testimony according to which "the omnipotence of love is perhaps nowhere more evident than in these, its aberrations."

#### TREATMENT OF HOMOSEXUALITY

The outlook for the treatment of homosexuality can be said to be the more favorable, the more pronounced the clearly neurotic element in its genesis is. Another favorable prognostic sign is, as we have seen,



the presence of a supportive father figure which, during the decisive years of early childhood, permitted at least a minimum of positive identification. Finally, the presence of heterosexual themes in the fantasies or dreams of the patient can be taken as a good omen.

The goal of treatment will differ, of course, according to the therapist's theoretical view of the nature of homosexuality. However, regardless of whether he regards strict heterosexuality or an eclectic bisexuality as normal, the analytically oriented therapist will strive to liberate the patient from the thralldom to his own, and only his own, sex and help him conquer his phobic fears of the opposite sex. Indeed, a gradual progress along the homosexual-heterosexual continuum is often achieved. For instance, a patient who originally responded only to athletic young men may begin to develop an interest in a somewhat tomboyish girl, and then little by little turn his attention to more feminine partners as the masculine component of his personality is strengthened.

There are, of course, homosexuals who maintain that they do not want to be cured of their homosexuality and who come to the therapist only in order to be relieved of certain neurotic difficulties. In such cases, it often turns out that the clinging to homosexuality is a façade behind which hides a more general fear of being changed by the therapist. The patient is afraid that the therapist wants to deprive him of something when, as a matter of fact, it is the therapist's purpose to open up a world of greater potentialities to him. Yet the very promise of a larger freedom arouses anxiety in an insufficiently prepared personality, and is experienced as seduction rather than as gift. The therapist will act accordingly and will seek out the patient on his own, anxiously constricted home ground. He will avoid uncalled-for brusqueness and will not contest the homosexual's mode of loving, however paltry, until something better—and better *from the patient's point of view*—can be offered.

As far as the outcome of therapy is concerned, it must be acknowledged that the results reported so far in the literature are not too encouraging. The most thorough and the most favorable data on this point are those of Bieber *et al.* (1962). In their sample of 106 homosexuals treated by psychoanalytic methods, 29 (27 per cent) were re-oriented to an exclusive heterosexuality. Of the 72 patients, however, who were exclusively homosexual at the beginning of therapy, only 14 (19 per cent) reached the goal of exclusive heterosexuality while a further 19 per cent were classified as bisexual at the end of the study. Among the 30 patients who were bisexual at the beginning of treat-

ment, a notable 50 per cent were brought to an exclusive heterosexuality.

The time element turned out to be a significant factor in the outcome of treatment: there was a noticeable increase in the chances of success with increasing duration of therapy. Of 38 patients who held out in treatment for 350 or more hours, no fewer than 18 (47 per cent) achieved the shift to heterosexuality; the comparable ratio for those who were treated for less than 150 hours was a slim 7 per cent (2 out of 28).

Interestingly enough, the probability of change from homosexuality seemed to be independent of psychiatric diagnosis. Homosexuals diagnosed as schizophrenic at the outset were as likely to shift to heterosexuality as those who had been diagnosed as psychoneurotics or character disorders.

One of the most favorable prognostic signs was the presence of a conscious wish to overcome homosexuality. Seventy-eight per cent of the patients who became heterosexual had expressed this wish at the outset of treatment. The most unfavorable prognostic item was the failure to *attempt* heterosexual intercourse at any time, whether on the subject's own initiative or on that of a partner.

Bieber's patient population was a highly motivated one. While no exact figures are given, we are told that a large number of these patients sought out psychoanalytic treatment on their own initiative, others having been referred by friends, physicians, clinics, or agencies. All of them were willing and able to make the considerable sacrifices required by psychoanalytic therapy. Thus, the composition of the sample may explain in part why the treatment results reported by Bieber—27 per cent of "conversions" to heterosexuality—compare so favorably with those published by other investigators (Knight, 1941; Woodward, 1958; Curran and Parr, 1957).

# 7

## The Psychoses

The psychoses are the most severe form of emotional disorder; they constitute one extreme of the psychopathological continuum. Of all the conditions which have been labeled "mental illness," it is the psychoses which most nearly approach the traditional biological concept of disease.

The psychoses are subdivided into two kinds: the *organic* and the *functional*. The former are characterized by the presence of a demonstrable lesion in the nervous system, whereas, for the latter, such a lesion cannot be demonstrated. Organic are the psychoses associated with such infectious diseases as general paresis or encephalitis; those connected with brain tumors or head injuries; psychotic reactions to poisons or metabolic disturbances; and the psychotic syndromes resulting from alcoholism, among which delirium tremens and Korsakoff's reaction are the best known. The functional psychoses embrace chiefly the large complex of illnesses covered by the term "schizophrenia" and the manic-depressive disorders.

In view of what has already been said, it will cause no surprise when we extend our doubts about the legitimacy of the somatogenic-psychogenic dichotomy to the domain of the psychoses, attributing no more than a relative validity to it. We will make use of this common distinction, however, for the heuristic purpose of limiting our theme: we will exclude the so-called organic syndromes from further consideration in the present study. There are both practical and theoretical reasons for so doing in that these syndromes scarcely present any new theoretical problems to the nonmedical man; their description no less than their understanding presupposes a certain familiarity with nervous anatomy and physiology; and their incidence, except for that of the alcoholic deliria, is rather limited. Hence, we



will merely mention their existence here, noting that there are psychotic disorders which are correlated with clearly demonstrated anatomical defects in the brain and central nervous system, these defects commonly being looked upon as the cause of the disorder.

The principal feature of psychotic disorder is said to be the loss of contact with reality. The patient can no longer draw any line, or any reliable line, between his own subjective, imagination-laden inner world and the outer world of socially validated reality—the “real external world.” The psychotic distorts the “objective reality” which others see; he displaces and restructures it, to the point, in severe cases, where orientation in space and time is lost: the psychotic sometimes no longer knows where he is, what day of the week, or even what year it is. It is the psychotic to whom the paragraphs of the criminal law which refer to “insanity” apply, and the attempt has been made to define psychosis, in the simplest terms, as a condition where the patient “is unable to take care of himself, being dangerous to himself or others or both.” It is usually, though not always, true of the psychotic that he lacks insight for his condition, that he does not know he is sick.

Many investigators hold that there is a gradual transition from neurosis to psychosis, with a partial loss of reality being observable also in the former. They think in terms of a genuine neurotic-psychotic continuum of pathology. Other investigators, however, make a sharp distinction between the two kinds of disturbance, and maintain that the difference is a qualitative one which cannot be reduced to quantitative divergence. These writers take the view that, in comparison to neurosis, the psychosis presents something radically new, and that a prepsychotic personality is fundamentally different from a neurotic one. Be that as it may, we do in practice often observe cases where what looks like a neurotic condition seems to slide over into a psychotic state—and also, inversely, the gradual fading of a psychotic episode into a neurotic condition, or something closely akin to it.

Like homosexuality, the psychotic state is the theme of countless myths and stereotypes which convey a misleading picture to the layman. People are especially prone to visualize psychosis as a disease that is necessarily dramatic and wildly gesticulating, easily recognizable at a distance. The image of the “raving maniac” continues to float around as the prototype of the psychotic. In reality, however, as anyone with experience in this field knows, the psychotic is often very difficult to recognize as such. Thus, many a layman, visiting for

the first time a mental institution or the psychiatric ward of a general hospital, expresses his astonishment at the fact that many of the patients present a perfectly normal appearance, with the result that he may come to feel that he has somehow wandered into a kind of cabinet of Dr. Caligari. Even general practitioners and medical specialists who are not wholly unacquainted with psychiatric syndromes sometimes show surprise when one of their patients, whom they thought they knew well, turns out to be suffering from a psychotic disorder.

The only psychotic conditions which are easily recognized as such are the extreme forms of mania and melancholia, as well as certain especially dramatic forms of schizophrenia, such as catatonic stupor or hebephrenic silliness. But other psychotics, who are just as sick, may go undetected for a life time. Such are the simple schizophrenics with unobtrusive symptoms, from which Bowery type hobos and social drifters are often recruited. Equally difficult to detect are the so-called pseudo-neurotic schizophrenics, in whom the psychosis is hidden behind a florid set of neurotic symptoms. Some of the most dangerous psychotics are extremely hard to identify as such. Paranoid psychotics in particular often appear to be very rational, composed individuals, until one fine day, without visible provocation, they suddenly go berserk. The innocent bystanders cut down by the fire of a wildly wielded pistol turn out to have been emissaries and spies of the "enemy" in the paranoid system of their attacker. Such homicidal outbursts, sensationally played up by the press, seem to the public more common than they are, but remain, nevertheless, not-to-be-excluded possibilities in the case of some of the most harmless looking paranoids.

Even a psychiatrist sometimes has trouble diagnosing a psychosis, and it is often important to be able to do so as early as possible since both his general prognostic expectations and his way of dealing with the patient may depend on his diagnosis. To conclude that a patient is psychotic means to ponder the increased hazard of extreme destructive acts. Thus, for example, it is crucial to distinguish a psychotic depression from a neurotic (or reactive) one, since the danger of suicide is much greater with the former and hence hospitalization to be more seriously considered.

Diagnostic classification and nosology are particularly unsatisfactory in the area of the functional psychoses. With the neuroses, we have the progressive metamorphosis of anxiety as an ordering principle; in the case of the functional psychoses, such systematic guide-



lines are missing. The division between the two main groups—manic-depressive reactions and schizophrenic reactions—is largely heuristic, and it is not always easy to make a clean differential diagnosis. All kinds of mixed and transitional forms are met with. As for the subdivisions among the schizophrenias, they are so diverse, heterogeneous, and full of overlap that a diagnostic consensus is often next to impossible. In such cases the alacrity with which one is prepared to make a diagnosis is in direct proportion to one's relative ignorance of the case at hand.

There is, however, general agreement on one point, namely, that manic-depressive states are usually less malignant than schizophrenic reactions. The reasons for this are as follows:

1. Manic-depressive states usually are followed by spontaneous remissions, or entail lucid intervals between manic and depressive episodes.
2. They involve less personality disorganization; the personality is less fragmented, and the psychotic mood is integrated with the total character pattern.
3. If they deteriorate, the change is sometimes in the direction of schizophrenic states; thus, at least in some cases, a worsening of the pathological condition means a transition from a manic-depressive to a schizophrenic state.

Some authors would disagree with this last point and maintain that in such cases the initial diagnosis was mistaken and that the correct label would have been, "schizophrenia with manic-depressive overlay." This shows once again how large questions of classificatory verbiage loom in this field, and how unsatisfactory the diagnostic nosology really is in clinical use.

As we might expect, and as we will discuss in more detail below, the field of the psychoses provides a favorite battleground for the skirmishes between the somaticists and the proponents of a psychogenic etiology. It is little wonder that the somaticists are so numerous and vociferous in this area, since the disturbances in question appear in many respects to behave like organic illness. It is certainly true that disorders in physiological functioning have repeatedly been observed in psychotics—such things as abnormalities of the metabolic, endocrine, and other biochemical or biophysical coefficients. This has often led to overhasty conclusions about the causal primacy of such somatic irregularities. Many investigators are impressed by the appar-



ent absence of any reasonably plausible psychic cause (in the form of some life experience) for the outbreak of certain manic-depressive or schizophrenic episodes. Some observers also note that the "process-like" course of these diseases, involving insidious deterioration or sudden remissions, seems to be fairly independent of any events in the patient's life history. Where psychological experiences and motivations seem to go along with the course of the disease, they are usually held to be "etiologically inadequate" by the somaticists. Positive findings from genetic research, although methodologically less than compelling, are of course grist for the somaticists' mills, as is the observation, repeatedly confirmed during the last decades, that psychotic states can be remarkably influenced by pharmacological and other methods of somatic treatment (tranquilizers, insulin and electroshock, and so on). The production of "model psychoses" by means of hallucogenic drugs, such as mescaline or lysergic acid, has also been booked to their account by the somaticists. All such findings naturally do not prove in any rigorous logical sense the thesis of somatic etiology, but, in the heads of biologically predisposed investigators, they constitute strong presumptive evidence in its favor.

On the other hand, successes in the treatment of psychoses by psychotherapy are just as little proof that these disorders are "basically" psychogenic. And neither of the contesting theories is intrinsically more optimistic in the sense that its corroboration would be necessarily more likely to lead to the discovery of a definitive cure. Not only organic damage may be irreversible, but psychogenic injury as well. This point must be stressed in the face of the nowadays fashionable, but mistaken, belief that psychic traumata are always curable in principle, and that the right combination of psychotherapeutic love and technical competence is a universal remedy against all psychogenic afflictions.

### *Manic-Depressive Disorders*

The manic-depressive psychoses are essentially disorders of affect and of mood. The capacity for clear thinking remains, and the personality as a whole is not damaged. These patients are not insane in the sense of being unable to think logically, although an impairment of judgment can be often observed as a secondary consequence of the disturbed emotional state. Statistically, the manic-depressives constitute about 14 per cent of the new admissions to mental hospitals and

psychiatric wards. However, their percentage share in the institutionalized psychiatric population (what the epidemiologists call the "prevalence" as opposed to the "incidence" of a disease) tends to run lower than the admission rate, because the manic-depressive psychoses are among the less prolonged mental disorders.

As the name suggests, manic-depressive disturbances are characterized by the periodic alternation between so-called manic and depressive phases, which follow each other, sometimes with a minimum of transition. In addition to this type there are cases where either the manic or the depressive condition dominates the clinical picture, to the almost total exclusion of the alternate phase. Strictly speaking, then, we distinguish three syndromes—manic-depressive states proper, depressed states, and manic states—whereby the last two can be viewed as partial syndromes of the complete manic-depressive picture.

#### THE DEPRESSIVE STATES

Depression is characterized by dejection, general sadness of mood. In the more extreme states, the patient is retarded in his psychic and physical reactions, the slightest expenditure of energy (getting up in the morning, rising from a chair) is too much—the sick person feels hollow, drained out, empty of love. His entire world has lost its luster, appears to be framed in black. The basic mood of these patients is gloomy, and they live in constant apprehension of a great catastrophe; they feel that any glimmer of hope, any stirring of optimism is childish illusion or even diabolical delusion. They suffer in particular from severe feelings of guilt and self-condemnation, inflating innocent peccadilloes to capital crimes and unforgivable sins. Such patients believe that they deserve death or the worst misfortune a thousand times over and feel unworthy to breathe the free air of heaven. Every person they pass on the street seems infinitely better than they, and quite justified in inflicting deserved punishment. This feeling of total self-condemnation can easily shift into suicidal impulses, with the danger being greatest at the beginning and end of the melancholic phase; during the height of the depression, the suicidal risk is paradoxically less, on account of the general retardation and paralysis of action. In terms of habitus and physiognomy one recognizes the depressive by his crushed, downcast stance, the dead gaze and dryness of the eyes, as well as the peculiar folds around the eyes which Veraguth has described. Many of these symptoms reach their greatest intensity in the so-called depressive stupor where the patient seems to have been petrified into a pillar of stone.



## THE MANIC STATES

In many respects, the manic state is the exact opposite of depression. Here the psychic and physical habitus is gay, speeded up, buoyant. In contrast to the leaden thought processes of the depressive, ideas come with lightning speed, stumbling over one another, with consequent logorrhea and lack of coherence. The patient sees the resistance and obstinacy of sluggish reality vanish, his efforts take wings, becoming easier with each passing moment, like those of some recently earth-bound Icarus who of a sudden is released from cloying gravity and feels resistance to his flight dwindle as he soars into the increasingly rarefied atmosphere. So too the basic mood of the manic is triumphant and joyous, his self-confidence limitless. No obstacle seems insurmountable, no enterprise too difficult. In their boastful, expansive demeanor these patients resemble drunkards. Sometimes they reach the point of megalomania, of delusions of great wealth and accomplishment. Yet these delusions do not bear the impress of incorrigibility, as do those of the paranoid; they are more characterized by blustering boastfulness which draws back to less exposed positions in the face of serious challenge. The bodily demeanor of the manic is proud, energetic, preening. His face is flushed, and his eyes shine with "manic brilliance." His sleep is uneasy and agitated, his waking activity ceaseless. One could easily take him for a darling of the fates, a favorite of fortune, if it were not for the fact that his febrile agitation, blinding his judgment, continually gets him into hot water. Thus, he may get involved in business deals which are far beyond his actual and potential means. Nor can the careful observer escape the impression that all this frenetic activity is frequently no more than a desperate attempt to ward off ominously impending depressive moods.

## PSYCHODYNAMICS

As a matter of fact, mania has often been interpreted as a "flight into reality," as a defense against underlying depression. Hence, it seems appropriate to examine at first the depressive reaction and its psychological significance.

Two main features have been consistently associated with depressive reactions, namely, loss of love and deflation of self-esteem, the former one frequently precipitating the latter. Depression was interpreted by Freud as a pathologically exaggerated reaction to the loss of a love object, an abnormally heightened and distorted form of



grief and mourning. The crucial difference lies in the fact that grief is a conscious reaction to a consciously experienced loss, whereas in melancholia the object loss is unconscious. The depressed patient does not know what he is really depressed about.

A more articulate psychoanalytic interpretation conceives of depression in terms of an exacerbated intrapsychic conflict between ego and superego—a conflict often activated by the loss of a loved person. The loss of the beloved object is seen as mobilizing severe guilt feelings, usually in reaction to more or less unconscious feelings of hostility which had previously been successfully repressed, but have come out into the open with the disappearance of the beloved person. It is as though a sadistic and vituperative superego had only waited for this occasion to pounce upon a more or less dazed and defenseless ego, to crush it under the burden of accusation and reproach. The genesis of such a sadistic superego is seen by psychoanalysts to be a frequent result of originally powerful aggressive feelings toward others. Because of their violence, however, dangerously compromising in a non-sympathetic environment, these feelings had to be contained.

The opinion is widespread among psychoanalytic clinicians that the vulnerability to depressive attacks is intimately related to psychic traumata suffered at the oral stage of psychosexual development. This seems to be borne out by the observation that oral themes play a dominant role in the fantasy life of such patients. As a rule the nourishment function is among those affected. Loss of appetite is a regular feature of the depressive picture, and in extreme cases leads to a complete refusal of food. Also the disappearance of the depressive stage and the inception of the manic stage is often heralded by an abrupt recovery of appetite.

It appears as though the vital elixir of love is, with such patients, closely related to the life-giving milk of the mother. Some kind of feeding frustration in early infancy may have made them forever vulnerable to any reduction in their "emotional supplies." Any such reduction seems to pose for them a real threat to their survival.

The milder forms of depression have been interpreted in a similar manner. These reactions, which are known as *neurotic* or *reactive depressions*, are often the result of changes in the social environment which sensibly reduce the supply of love and affection. The reactive factor is particularly evident in these milder depressions, in contrast to the massive attacks of melancholia which frequently appear to start out of thin air, in the absence of any major trauma such as the visible loss of a loved person. Such cases often require prolonged psycho-

logical exploration before one gets at the snarled skein of motivation. However, Lindemann and others have been able to show that in a great many cases the outbreak of a depressive psychosis does, in fact, occur in close temporal proximity to the actual loss of a near relative.

From a functional point of view, the behavior of the depressive can be interpreted as a desperate, pathetic appeal for crumbs of love—an appeal which because of its desperately uncertain, beseeching note is often self-defeating.

It is as a flight from all this that the *manic* condition has been interpreted. The patient seeks to escape into an artificial paradise of hectic activity, to get away from the underlying depression which threatens to engulf him. It is noteworthy that a hidden sense emerges from the apparent nonsense of much manic rambling ("flight of ideas") as soon as one notes that the will-o'-the-wisp mind of the patient makes a particularly desperate leap whenever he gets near a topic with potentially depressive undertones. Ludwig Binswanger has attempted to understand the "manic triad" of compulsive activity, flight of ideas, and euphoric mood as articulating a "leaping style of life." And it is hard to escape the impression, when observing such patients, that their leaps are driven less by exuberance than despair.

Kraepelin, one of the pioneers of modern psychiatry, first advanced the notion that manic-depressive disorders are the psychic reflection of somatic dysfunction, probably metabolic in nature. Kraepelin was particularly impressed by the cyclical, periodic character of the disease, the ups and downs of which did not seem to be correlated in any plausible manner with events in the life history of the patient. But Kraepelin's and his successors' attempts to prove empirically such a physiological etiology of these disorders have failed so far. Here again the question arises whether this laborious failure was not unavoidable because the way of posing the problem ("somatogenic or psychogenic?") was inadequate.

### *Schizophrenic Reactions*

The group of pathological reactions included under the collective label of schizophrenia contains those forms of mental disorder which most closely resemble the popular image of insanity. One finds here scary, weird, uncanny phenomena—such things as hallucinations, delusions, catatonic immobility, and fits of raving madness—phenomena which seem to be located at the most extreme limit of mental alienation. In contrast to the manic-depressive whose personality is rela-



tively untouched, the schizophrenic is quite literally unhinged, alienated, divorced from the world of generally accepted reality. The whole structure of meaning of his existence is shattered, and he seems to dwell in a transmogrified, irrational, idiosyncratic world. In the schizophrenic, we run up against the limits of the intelligible, and a heroic effort of the imagination is needed in order to gain access to his eccentric world and to empathize with him. In a certain sense, the schizophrenic is the unwitting explorer and herald of unfathomed boundary areas of human existence. In his illness, uncanny potentialities, which lurk in the shadows of every human existence, become real. He bears witness to an experience of universal import: the confrontation with primordial fear, surrender to naked horror, where the normally veiled or hidden aspect of the fundamental forlornness of existence is revealed with shattering impact. Viewed in this fashion, the madness of the schizophrenic transcends the category of mere pathological accident, and becomes an existential mode of being which puts into question the foreground of consensually validated, "objective" reality, and unveils the existence of other, backstage, realities which are no less real for being generally kept in the shadow. (It is chiefly existential analysts, such as Binswanger, Jaspers, Kuhn, and Wyrsh, who have taught us to view schizophrenia in this way.)

Doubts have been expressed on occasion as to whether it really makes sense to include all the various disease pictures which have been designated as schizophrenic under one rubric. The pathological phenomena which are embraced in the different subcategories are extremely heterogeneous. During recent years, several investigators have suggested that the concept of "*the* disease of schizophrenia" be either dropped or de-emphasized. They have proposed to sort out, from the undifferentiated medley of "schizophrenic" reactions, a number of individual syndromes and to investigate these carefully with regard to their psychological-somatic structures.

#### THE MAIN SYMPTOMS OF SCHIZOPHRENIA

There are, however, certain general features which are common to the clinical pictures of this group of disorders, and hence justify the retention of the concept of schizophrenia. For a long time, certain disturbances in psychic processes, which Kraepelin and Bleuler designated as *loosening of associations*, were rated as the main symptom of schizophrenia. The nature of these disturbances, most manifest in the intellectual sphere, consists in the failure of ideational and thought processes to conform to the laws of rational patterning.



The canons of logic no longer prevail, and the connections between successive contents of consciousness are of a different kind, looser and less ordered, than is the case in normal thinking.

Another major symptom of schizophrenia, at first emphasized by Bleuler, has gradually gained in diagnostic significance and nowadays is held to be at least as important as the criterion of intellectual slippage. This is the *blunting of affect*. Contemporary psychiatry tends to see this radical disturbance in the sphere of affectivity, with its loss of interest in the environment, and the withdrawal of libidinal investment in it, as the most ominous concomitant of schizophrenic reactions. Psychoanalysis, which is primarily a psychology of affectivity, has undoubtedly contributed to this change in emphasis.

The interest in the pathology of the thought processes never vanished entirely, however; it has recently been on the rise again, as witnessed by the work of Arieti, von Domarus, N. Cameron, and S. Mednick, among others. For the most part, these studies are less concerned with the content of schizophrenic thought than with certain of its formal peculiarities, which are a much more sensitive index of the disease. Several aspects have been stressed. Storch (1922) put forth the "archaic and primitive" nature of schizophrenic thinking, its tendency to reification and its affinity to dream thought, with its replacement of abstract ideas by concrete visual imagery. In this connection, Kretschmer (1926) spoke of "dereistic thinking." Goldstein (1943) emphasized the viscous concreteness of the cognitive processes of his schizophrenics, which he interpreted as a regression to the intellectual level of the two- or three-year-old child. In this view, he is at one with the psychoanalysts.

Arieti (1959), basing himself on Goldstein's work, speaks of the schizophrenic's "active concretization": "The schizophrenic not only loses the abstract"—as Goldstein teaches—"he transforms the abstract into the concrete" (Arieti, 1959, p. 476). Arieti goes on to interpret hallucinations as such concretizations of the abstract: "For example, a patient who, before the onset of the psychosis, had a very low opinion of himself, especially on account of his homosexual desires, now has an olfactory hallucination. He smells an awful odor emanating from his body. Here again we have a perceptualization of the feeling he has toward himself: he is a rotten character, he stinks" (Arieti, 1959, pp. 476-477).

Another peculiarity of schizophrenic thinking is the "psy-

chotic insight," which combines previously disparate delusional ideas into one ideational system, and thus achieves the pleasurable (psychoeconomic) gain which always goes with the sudden falling into place of previously unconnected observations—even when, as in the present case, this falling into place represents the crystallization of a delusional system.

Most researchers believe that the anomalies of schizophrenic thinking do not arise from a partial destruction of the intellectual apparatus, but rather from its pathological misuse. The *capacity* for straight thinking remains unimpaired. This view is supported by the variable level of intellectual performance exhibited by schizophrenics on psychological tests, as well as by the full restoration of normal thought after the disappearance of the acute episode.

As far as the disturbance in *affect* is concerned, we must add that periods of complete apathy and withdrawal may be interrupted by periods of explosive affective discharge. These are frequently characterized by a marked dissociation of affect, by the apparent lack of an adequate motive which could be said to have released the intense outburst of emotion. The patient may suddenly burst into wild tears, without being able to recognize any ideational content connected with his manifestation of misery. He may present all the external behavioral signs of extreme despair without being sure of whether he really *feels* desperate. In other instances, to be sure, the affect may be recognized, at least by an observer, as a response to an identifiable external stimulus, but appears to be remarkably inappropriate, out of context. An example of this would be the mysterious smile with which a certain patient meets the news that a close relative has died. On closer exploration, it may turn out that this odd smile had, in fact, a very definite meaning within his delusional system. It may result, for instance, from the seeming confirmation of paranoid feelings of omnipotence. The patient believes that it was his magic which converted an ephemeral wish (for the death of the relative) into reality, and exults at this proof of his power.

As far as the external picture is concerned, the patient appears shy and withdrawn in his apathetic periods, sparing in gesture and lost in dreamy thoughts, oblivious to what goes on about him. This condition can increase to a fully stuporous paralysis—the catatonic stupor—where the patient appears literally dead to himself and the world.

The periods of affective discharge present just the opposite picture. The patient is excited, feverishly active, and exaggerated to the point



of caricature in his gestures. Such catatonic excitement can go to the point of a maniacal explosion with homicidal attacks or attempts at suicide. Many schizophrenics show a robot-like tendency to imitate the gestures or bodily movements of others; they may indulge in all sorts of weird, silly-looking gestures and rituals, which are often extremely intricate and accompanied by necromantic incantations; they may adorn themselves, Ophelia-like, with trash, rags, weeds, and gaudy trinkets. In this phase, their behavior strikes one as particularly crazy and meaningless, but the psychiatrist who is acquainted with the unconscious fantasies and the life history of the patient is quite frequently able to decipher the secret meaning of these abstruse proceedings.

It is plainly evident that many patients are actively delirious or hallucinating, that they see things others don't, that they are deeply terrified or highly delighted, that they hear voices inaudible to others and listen carefully to them, or that they react to the pseudo-presence of an imaginary partner.

#### THE SUBGROUPS OF SCHIZOPHRENIA

Schizophrenics are divided into six diagnostic subgroups according to which of the various features and symptom-complexes just described dominate the clinical picture.

When the behavior is for the most part unobtrusive and characterized chiefly by poverty of affect and lack of human relatedness, with perhaps a certain eccentricity or oddness added, then we speak of *simple schizophrenia*. There is good reason to believe that many cases of simple schizophrenia go undetected for a lifetime, and many hoboes, tramps, Bowery types, odd-balls, hermits, and social drifters, as well as members of the middle and upper classes who appear to be caught in a ceaseless, hard to explain, social descent, may be assumed to suffer from this disorder.

When delusional thinking predominates, with fragmented or systematized ideas of persecution and reference, with fantasies of cataclysm and of the self as prophet or Redeemer, then we speak of the *paranoid* variant of schizophrenia. Such patients may make a quite well-ordered and reasonable impression, and, like the simple schizophrenics, may not be judged sick by people around them. On closer acquaintance with them, however, it is always possible to detect secret eccentricities, such as the furtive hoarding of food or other supplies, the keeping of diaries in mirror-script, the preposterous collection of documents, the barring of doors, or the construction of codes so



complex as to be self-defeating. Their behavior frequently resembles that of an inane secret agent in highly dangerous enemy territory who betrays himself to the practiced eye either through his conspiratorial pussyfooting or his exaggerated nonchalance.

We classify as *catatonic* reaction those patients who stand out because of their transfixed rigidity, or their feverish, unmodulated excitement. Those who impress us with the obvious deterioration of personality, with childishly silly, eccentric, and ritualistic elements in their behavior we assign to the *hebephrenic* group. Finally, we have to use the wastebasket category of *undifferentiated* schizophrenia for all of those patients in whom none of the specified symptom complexes clearly dominates the clinical picture. As the presence of this last category suggests, it is often difficult to assign a patient to one of the subgroups. The critical signs of the various nosological categories are not mutually exclusive, so that it is always a question of more or less, of the relative preponderance of a particular symptom complex. Diagnostic disagreements among clinicians, one or more reclassifications of a patient by the same observer, and other indications of diagnostic perplexity are by no means exceptional.

In the last decade or so, still another subcategory has been taken up into the diagnostic schema of schizophrenia. This is the rubric of *pseudo-neurotic schizophrenia* first proposed by Hoch (1949), and intended to fit a form of the illness in which a schizophrenic loss of contact is obscured by a foreground of neurotic symptoms. The loss of contact is, however, less than in the full-fledged forms of schizophrenia, and such patients exhibit reality-adjusted behavior and reality-estranged delusions side by side. Typically, they show an all-pervasive anxiety structure (or "pan-anxiety") which leads to a rich efflorescence of every imaginable neurotic symptom (anxiety neurotic, hysterical, phobic, and obsessional) but only seldom to episodes of total psychotic regression. The pseudo-neurotic schizophrenic is often mistakenly identified as a true neurotic for years and treated as such until the psychotic element unmistakably declares its presence.

Another diagnostic distinction which is emphasized in many places and which, so to speak, cuts across those described above, is the distinction between *reactive psychoses* and *process psychoses*, corresponding more or less to the distinction between reactive depression and endogenous depression. As their name implies, reactive psychoses are seen as reactions to unusually disturbing events in the environment—the loss of a close relative, an unhappy love affair, and the like. Breaking out abruptly as a rule, and taking a course full of dramatic

incident, they are likely to subside into remission, spontaneous or abetted by various forms of therapy. The process psychosis, on the other hand, appears as an insidious and apparently unretardable deterioration which comes on gradually and is inadequately explained by reference to external events. The chances for successful therapeutic intervention are felt to be not very good.

Recent attempts to establish experimentally the empirical fruitfulness of the process-reactive distinction have met with indifferent success (Becker, 1956; Finkelstein, 1953; Kantor *et al.*, 1953; Zimet and Fine, 1959; Zlotowski and Bakan, 1963). Little or no difference in psychiatric symptomatology was found to exist between the reactive and process groups; there was some but not very conclusive evidence of a differentiation in cognitive and perceptual styles. As for the outcome criterion, it may be easily criticized as tending to be circular in that patients who have not been cured are assigned to the "incurable" (process) group. Zigler and Philips (1962) suggest dropping the process-reactive dichotomy altogether, or rather reducing it to a dimension of social maturity which, according to them, is relevant not only to schizophrenia, but to all of psychopathology.

### *The Etiology of Schizophrenia*

This topic is a major battleground for the opposing forces of the somaticists and the proponents of psychogenic theories. The empirical data, psychological and physiological, upon which the opponents base their arguments are of course largely neutral in themselves, and can be subsumed under various, equally neutral concepts which leave the question of causal primacy open—for example, the concept of psychosomatic isomorphism or of psychophysical simultaneity. However, most investigators tend to give primacy to one or the other of the two series of observations (psychological and physiological). This may be due to the fact that previous attempts to go beyond this causal dichotomy have produced little more than pallid hybrid theories bearing the imprint of a spineless eclecticism (see below).

On the *psychological* plane, the tendency since the advent of psychoanalysis has been to look upon schizophrenia as a severe retardation of development, with subsequent disintegration of the personality. Many observers feel that a psychological interpretation of this kind is inescapable. They point to the premorbid personality of the victim,



often characterized, long before the onset of the acute disease, by oddness, hypersensitivity, vulnerability, uncertain ego boundaries, and a limited capacity for social contact. Personalities of this kind, which hide their vulnerability under the armor of cool indifference and aloofness, have been labeled as "schizoid." But schizoid is not synonymous with preschizophrenic; while psychotic decompensation sometimes overtakes these heavily insulated characters, it is by no means a foregone conclusion.

In their search for the crucial event in the schizophrenic's history, the psychoanalysts have focused attention on the earliest, or oral, period of infancy (Spitz, M. Klein). They speak of narcissistic regression and of a loss of reality, and compare the schizophrenic to the autistic neonate. The autistic retreat from the pressure of an inhospitable, malevolent reality is said to lead back to that amorphous, worldless stage of development where his tragically marked existence suffered the first of a series of fatal psychic injuries. The strange, apocalyptic end-of-the-world visions experienced by many schizophrenics are interpreted as the subjective reflection—distorted in its significance—of this reversion to the chaotic stage of early autism. Some analysts have stressed the difficulties which the preschizophrenic child suffers during the *Oedipal* phase of development, but they, too, would tend to agree with the orthodox position that the schizophrenic regression "reaches back to much earlier times than does any regression in neuroses, specifically to the time when the ego first came into being" (Fenichel, 1945, p. 515).

#### "SCHIZOPHRENOGENIC" MOTHERS?

Thus it is little wonder that the search for the crucial pathogenic factors has focused more and more on the earliest period of life. And since, during this period, the relationship to the mother is of unique, nearly exclusive significance, she was for a long time seen as the chief cause of schizophrenic vulnerability. Countless papers about the "schizophrenogenic" mother have been written, in which she takes on the lineaments of the wicked Witch-in-the-Wood. Cold, unloving, demonically powerful, evil-eyed, she commits her brood to certain perdition; from her breasts, in place of the life-giving milk, the innocent child imbibes a poisonous witches' brew and its dark promise of future madness. Such extravagant descriptions, which betray less critical observation than acquaintance with the mythology of the nursery, were long taken as legal tender, in particular by the guilt-ridden witch-mothers themselves. It is interesting that the scien-



tific or pseudo-scientific literature in this area contains no male counterpart remotely approaching the demonic mother in malefic potency, even though the mythology drawn on is not devoid of appropriate models.

Now it would be obviously ridiculous to deny that an overtly or latently pathological mother can exert a very destructive influence on her children, especially during the earliest stages of life. But a cooler, less frantic approach has enabled more recent research to reduce the pathogenic effect of such a mother to more realistic proportions, to demythologize the image of her personality, and to reinterpret the mechanisms of pathogenic influence.

As more empirical data have been collected, the dream of crystallizing out a *single* type of schizophrenogenic mother has collapsed. In particular, the primitive typology, according to which such mothers were invariably cold, heartless, aggressive, and clearly rejective, has proved fallacious. Nevertheless, certain, more subtle characteristics have been described, which have been found in a large number of mothers whose children have later become schizophrenic. Thus, many of these mothers turn out to have been especially intrusive, in the sense that they used their children as a means of living out their own dynamically intense, but unrealized, fantasies. Such mothers make it almost impossible for the child to develop an ego of its own, with clear boundary lines between the I and the not-I. The symbiotic relationship between mother and child is so intimate that it is practically impossible for the child to emerge as an independent personality without threatening the psychic or even the physical existence of the mother. Often enough, such a child is one whom the mother, for some reason of which she is unaware (the child may have certain features of an immoderately loved father or brother), has selected to be her special pet, and who then suffocates under an excess of maternal affection.

This particular mother-child constellation is but one of several possible which favor an eventual schizophrenia, although many investigators view it as especially prevalent and ominous. It is certainly clear that the opposite situation—the previously dealt-with absence of warmth and love from the mother—is also an important antecedent of the schizoid withdrawal. Maternal ambivalence has been stressed as being notably dangerous for the child. This is the situation where the child is, so to speak, addressed in two contradictory languages. For example, the articulate speech of the mother may urge the child on to self-reliance and independence, whereas her language of gesture

and behavior informs the child that she would really like to maintain him in a state of infantile helplessness. This "double bind" dilemma (Bateson, Don Jackson) challenges the child to solve a problem which in its very nature is not solvable: he is supposed to become independent and to remain dependent at the same time. The challenge produces disorientation and severe anxiety, which can be seen as precursors of the later schizophrenic breakdown.

#### A TYPE OF "SCHIZOPHRENOGENIC" FAMILY

In recent years, a promising new approach has been developed, which broadens the focus of investigation to include the entire family, in particular the nuclear family of father, mother, and child. The basic idea here is that schizophrenia is less a disease of individuals than it is one of miniature social groups manifesting itself with special clarity in individuals. Proceeding from this assumption, Lidz (1957), Bowen (1960), Jackson (1958), and others have admitted selected schizophrenic patients, together with their immediate families, to the psychiatric wards of their institutions, in order to subject them to close clinical scrutiny.

One of their major findings was that, in all instances under observation, schizophrenia turned out to involve a familial pathology extending over two or even three generations. Without going beyond the nuclear family with its two generations, it was possible to show in every case that preceding the birth of the future patient there had been severe pathology present in the marital relations of the parents. As a rule, the relationship was characterized by a marked psychic remoteness, based on mutual immaturity, to which Bowen applied the term of "emotional divorce."

In detail, the situation often looked as follows: The immaturity of both partners led to an asymmetrical, rather rigid assignment of roles. One of the parents would hide his inadequacy behind a façade of hypernormal competence and self-assurance, while the other exaggerated his in the direction of infantile passivity and helplessness. Yet this arrangement, fulfilling deep unconscious needs of both partners, was usually resented by each of them. The dominant partner felt that the role of decision-maker had been forced upon him and that he did not get enough support from the other; the passive partner felt coerced into playing the part of a martyr and victim, forced to submit blindly to the will of the stronger. Yet neither dared to meddle with the equilibrium so established, however precarious they felt it to be. Often it was the wife who occupied the



dominant role in this pattern. But this discrepancy from the usual distribution of roles, which might be expected to add considerably to the pathology of the arrangement, turned out to be of secondary importance as far as the internal economy of the marital relationship was concerned.

The birth of a child poses serious questions for this basically precarious, yet previously enduring, equilibrium. The new arrival, often felt to be an intruder, can have both an upsetting and a stabilizing effect on the family system. His effect is upsetting because he disturbs the carefully established arrangement by his very presence; but it is also stabilizing in that, after the difficulties of the transition period, he may draw the pathology of the family on to himself, acting, so to speak, as a lightning rod. The helplessness and complete dependence of the infant permits the parents, and in particular the more passive parent, not only to feel more adequate, but also actually to play a more active role, at least in relation to the child. It thus becomes a prerequisite for the maintenance of the new equilibrium that the child remain in a dependent role, even when such a role has long since ceased to correspond to his deeper biological and psychological needs. The child's aspirations for autonomy, intensified during the period of adolescence, pose a catastrophic threat to the entire family. In this situation, the child yields to the demands for continued infantilism which have been thrust upon him—and which, remaining inarticulate, frequently collide with verbal demands to grow up. But the child ignores these verbal demands, which are meant to be ignored anyway, because he senses, quite rightly, that any attempt of emancipation on his part would threaten the survival of the family unit and his own existence. Besides, he draws important secondary gains from the role of passive helplessness, in the form of increased control over the parents. His position of weakness allows him to tyrannize the whole family, but the extreme discrepancy between psychological and chronological age eventually leads to schizophrenic atrophy.

The role of the father in this sort of family constellation is that of the peripherally attached family member, whose nearness or distance from the child is controlled by the mother. At times, with the express permission of the mother, he can be intimate with the child. His own pathology does not permit him to rebel decisively against the monopolistic position of the mother, and thus to establish a more direct relationship to the child.

The family constellation just described is unlikely to be the only



one which can predispose to the development of schizophrenia in the child, and it is also too schematic. Nevertheless, it points up the decisive observation of various investigators that the pathology of the marriage relationship itself and the individual pathologies of both partners constitute the preschizophrenic milieu which corrodes the developing personality of the child. This is borne out by the fact that an improvement in the relationship between the parents, a lessening of the emotional distance between them, frequently leads to a noticeable improvement in the symptomatology and general condition of the prepsychotic or psychotic child. Inversely, an improvement in the condition of the child, whether brought about by therapy or other circumstances, often appears to lead to the onset of psychological or psychosomatic symptomatology in one or both of the parents. This in its turn points up the homeostatic and stabilizing function which the child's pathology has for the family group. The small group model of the nuclear family and of its socialization function, as proposed by the sociologists Parsons and Bales, has proved useful in the descriptive analysis of these family constellations. An important pragmatic consequence of this new systematic approach is a therapeutic method which involves all members of the sick family, individually or together, in psychotherapy. This "family therapy" has led to gratifying results in the case of patients, be they children or adults, who are enmeshed in the intricate, tightly woven net of a pathological family constellation.

#### THE TRUTH CONTENT OF SCHIZOPHRENIC DELUSIONS

Existential analysts have endeavored to develop a phenomenological description and illumination of the schizophrenic's world. Binswanger's comprehensive, infinitely detailed case studies have been a major contribution to these efforts. He, along with Bally, Boss, and Storch, rejects the usual psychoanalytic view of the "loss of reality" on the part of the schizophrenic. Such a view, they argue, rests on the hidden premise that there is one, and only one, reality: the "objective" reality articulated most cogently by the natural scientist. They insist that the schizophrenic has a world and a reality like anyone else, but that the scheme of this reality differs from that validated by the intersubjective experience of the collectivity to which he belongs. Storch in particular has stressed the "truth content of schizophrenia." He sees this disease as one which "in peculiar variations . . . makes manifest the genuine, previously hidden reality of the patient." Thus, the delusional images "contain an existential

truth. . . . What is really at stake in the schizophrenic psychosis is the fulfillment of unrealized possibilities of being. In the very self-alienation and self-loss of psychosis the issue is self-realization" (Storch, in Stern, 1958, p. 234).

The existential truth contained in a psychotic delusion was particularly transparent in the case of Laing's (1960) schizophrenic patient Julie, a young woman who was in her middle twenties and had been hospitalized for nine years when Laing met her. When her illness first declared itself, at the age of seventeen, she made the delusional statement that "a child had been murdered." She was vague as to details, but mentioned that the child was wearing her clothes when it was killed. She accused by turns the mother and herself of having committed the murder. She was going to inform the police.

Now, on the face of it, these statements were obviously deluded. No child had been physically killed, and there was no evidence of a crime with which the police were equipped to deal. Yet her accusations needed little translation to yield their existential truth. A psychological crime had indeed been committed in that the child in herself, her child-like possibilities of being, had been smothered. Cheated out of her childhood, she could not grow into a full-fledged adult. In her prepsychotic days, she had accused the mother, in more rational language, of not "letting her live." When nobody believed her, she fell back upon the "delusional" statement that a child had been murdered. She ended by "converting existential truth into physical fact" (Laing).

At a later stage of her illness, when she had withdrawn further into her schizophrenic world, her language grew more hyperbolic and opaque. Her utterances were no longer directly translatable into existential statements; she herself had to provide the key of translation.

Thus, talking of herself in the third person, she said:

"She was born under a black sun.

She's the occidental sun."

Julie had always insisted that her mother had never wanted her. She had been born under an ill-fated, sinister "black sun," crushed out of her mother's body, rather than brought into the world normally. Her mother had "wanted and not wanted" a



son. She was an "occidental sun," that is, an accidental son whom her mother out of hate had turned into a girl. The rays of the black sun scorched and shriveled her. Under the black sun she existed as a dead thing. "This existential death, this death-in-life, was her prevailing mode of being-in-the-world" (Laing, 1960, p. 22). It was this desperate existential truth she depicted in the stark twin images of the "black sun" and the "occidental sun."

It is one of the merits of existential analysis to have sharpened our ear for the "truth content" of psychotic utterances. By recognizing the implicit validity of the schizophrenic's reality (of his "world-design"), the claim to absolute, exclusive validity, which the normal person's construction of "objective" reality implies, is badly shaken. One begins to recognize that the "normal" conceptions of reality are also dependent on wholly specific ways of one's being inserted in the world, which may slowly change over time and hence lead to a redefinition of what is "real."<sup>1</sup>

#### THE HEREDITARY FACTOR

Among those who stress the *somatic* aspects of schizophrenia, we will first mention the *geneticists* who look upon this disease as hereditary, or at least hold that a predisposition to schizophrenia is hereditary.

Among research which has dealt with genetic factors in the etiology of schizophrenia, the work of Franz Kallmann is most widely known. First in Berlin and later in New York, Kallmann studied the family histories of a large number of schizophrenics. In his twins studies of the 1940's, which were based on 953 pairs of twins in the psychiatric hospitals of New York State, he came to the conclusion that the probability of developing schizophrenia for the fraternal twin of a schizophrenic was 16.4 per cent, while for the identical twin of a schizophrenic it was 86.2 per cent. In general, the probability of developing schizophrenia seemed roughly proportional to the degree of consanguinity with a schizophrenic patient. Statistical analysis of his results led Kallmann to the conclusion that single-factor inheritance of recessive type is involved in the genetic transmission of the disease. In other words, that schizophrenia is due to a single

<sup>1</sup> When this generally accepted definition of reality becomes too narrow and has to exclude too many phenomena as "unreal," we are in a situation of crisis which manifests itself in the individual as neurosis or psychosis, and on the collective plane as a sense of general malaise which may culminate in apocalyptic expectations of cosmic catastrophe.



defective gene which, in the presence of the corresponding normal gene, does not affect the phenotype. Other geneticists (Slater, Böök) arrived at statistical results similar to Kallmann's, but have postulated a different mechanism of hereditary transmission.

It is interesting to note with how little critical sense the proponents of a genetic explanation of schizophrenia have accepted Kallmann's figures and relied on them for support. It is in general an interesting commentary on the methods of modern psychiatric research to note how frequently comprehensive and widely accepted hypotheses are based on the more or less debatable research results of a few investigators or even of a single worker. Pastore (1949) was so impressed by observations of this kind that he felt compelled to relate them to general cultural and ideological factors, as part of the sociology of science. In his book *The Nature-Nurture Controversy* he seeks to show the existence of a profound affinity between the social and political attitudes of a group of investigators and their espousal or rejection of genetic factors. According to Pastore, a point of view which de-emphasizes the formative influences of the environment and views heredity as Fate is frequently coupled with extreme conservatism in political matters.

For quite a while Kallmann's figures, research methods, and results were accepted rather uncritically by many workers; recently, however, they have been sharply and incisively attacked. The substance of the criticism has been to the effect that both the basic data and the nosological categories used were unsound, and that many of Kallmann's diagnostic decisions were based on circular reasoning. For example, the presence of "family taint" was accepted as a diagnostic indicator of schizophrenia. Further, his methods of statistical analysis were called in question. But the most impressive argument, especially well formulated by Jackson (1960), states that neither Kallmann nor any other geneticist has achieved a convincing separation between nature and nurture, between hereditary and environmental factors. Jackson directed a particularly devastating fire at Kallmann's oft-quoted twins studies, with their impressive convergence figures for identical twins. As Bleuler had already done, Jackson showed that identical twins have a unique environment and thus cannot be compared to fraternal twins on a genetic base alone. He referred to the problem of ego fusion—the difficulty of establishing a separate identity. Jackson notes that *folie à deux* with its shared delusions is a common occurrence among identical twins, as the intertwining of identities would lead one to expect. Jackson sees further support for the psycho-

dynamic explanation in the fact that concordance (a bilateral falling ill with schizophrenia) is significantly greater for like-sexed fraternal twins than for fraternal twins of opposite sex, and also greater for dizygotic twin pairs in which both are female than for those in which both are males. Such observations, extremely difficult to explain on any kind of genetic basis, fall easily into place when one considers that the psychic distance between like-sexed twins tends to be less than that between twins of opposite sex, and that our culture permits an intimacy between women which it punishes in males with the opprobrium of sissiness or the suspicion of homosexuality.

Kallmann and his supporters have stressed time and again that their genetic hypothesis does not necessarily negate the importance of psychological factors in the etiology of schizophrenia. In fact, in its present-day version, the genetic hypothesis holds that what is hereditary is the predisposition to the disorder, to which stress must be added in order to precipitate the actual disease. "Heredity is not Fate, but impending fate" (Luxemburger). In this form it is difficult either to prove the hypothesis or to disprove it. At any rate, the empirical material advanced up to now in support of the genetic theory has been far from conclusive.

#### PHYSIOLOGICAL CORRELATES OF SCHIZOPHRENIA

While the question of the genetic factor in schizophrenia is important, the primary research efforts of the somaticists have been bent in another direction. They have focused on trying to establish the exact biological mechanisms supposedly underlying the psychic manifestations of the disease. Since the days of Kraepelin, a truly mountainous amount of literature on the organic substratum of schizophrenia has piled up, the net yield of which has been close to zero. One by one, almost every domain of anatomy, physiology, and biochemistry has been investigated with regard to its possible etiological significance: cell metabolism, the endocrine system, neural anatomy, and physiology have had their turn as the main suspects. Time and again, correlations have been reported, which at first sounded promising, only to collapse under the burden of further investigation.

Every technical innovation or chance empirical lead, such as Sakel's discovery of irregularities in the insulin metabolism of schizophrenics in the 1930's, or Berger's discovery of electric brain activity in the 1920's, has sent hosts of investigators down new alleys of exploration all of which terminated in dead ends. Just a few years ago, the discovery of the role of serotonin (a neurohumoral agent) in the



biochemistry of the human organism caused considerable excitement. It was shown that serotonin acted as a neurophysiological antagonist to lysergic acid which had been widely used in order to induce "experimental psychoses." Certain irregularities of serotonin concentration in schizophrenics were reported. It was also noted that the drug reserpine, widely used as a tranquilizer with schizophrenics, tended to depress the level of brain serotonin. It was tempting to conclude that reserpine owed its tranquilizing effect to an action on serotonin metabolism that as yet was not fully understood. But more thorough empirical investigation brought to light evidence inconsistent with the serotonin hypothesis. A bit earlier, a metabolic toxin called taraxein had been singled out as a possible schizophrenic agent. But again the hopeful excitement generated by initial positive leads was soon deflated by more thorough empirical work.

#### THE EFFECTS OF HALLUCINOGENIC AND TRANQUILIZING DRUGS

In the last few years, much research effort has been spent also on exploring the effects of so-called hallucinogenic drugs (lysergic acid, mescaline, and others). By artificially inducing, with the help of these drugs, psychotic-like states in experimental subjects, one hoped to shed light on the mechanisms involved in the genesis of schizophrenic states.

The states induced by lysergic acid, mescaline, and similar drugs appear to mimic schizophrenia in that they may produce, in normal subjects, a rich efflorescence of illusions, visual and auditory hallucinations, synesthesias, and euphorically elated or anxiously depressed moods. The hallucinatory images accompanying these states may be of dream-like intensity, conveying visions of ecstatic bliss or shattering horror.

A major avenue of research has been to compare the reactions of normals and schizophrenics to the hallucinogenic drugs. Hoch found that mescaline tended to produce less anxiety and apprehension with normals than with acute schizophrenics. With the latter, the drug frequently elicited sexual fantasies and behaviors, but only rarely with normals. The physiological concomitants were pretty much the same for both groups, as were the grosser qualitative distortions of psychic functioning: disturbances of the body image and feelings of depersonalization were common to normals and schizophrenics. The main difference in this respect was a quantitative one: more pronounced disorganization of thought and of affectivity with the schizophrenics. The normal subjects, retaining a better hold on reality,



remained more distant vis-à-vis their perceptual disturbances. In burned-out schizophrenics of long standing, mescaline did not produce much of any psychological effect, but miscellaneous, subjectively unpleasant, somatic symptoms. With pseudo-neurotic schizophrenics, the drug would bring out the latent psychotic symptomatology, precipitating feelings of depersonalization and intense anxiety. These patients appeared to suffer most intensely from the drug-induced symptoms (Hoch, 1959, pp. 1697 ff.).

One of the more valuable by-products of the experiments with hallucinogens was the reaffirmation of the importance of the individual factor. The subject's personality make-up, more than anything else, seemed to determine the nature of the psychic reactions to the drugs, the range and variability of which were extreme. Cattell, investigating the influence of mescaline on psychodynamic material, noted that in the perceptual alterations certain universal ("non-specific") changes occurred, common to all subjects, and linked to a very primitive type of fear or pleasure response; but in addition specific responses emerged which were meaningful in the context of a particular personality configuration and were clearly related to the needs and concerns of the individual in his usual drug-free state. Even when trends emerged which had not been recognized prior to the ingestion of the drug, they could be fitted without difficulty into the personality profile. Only rarely did material come to the fore which clashed with what was known about the person (J. P. Cattell, 1954, pp. 119 ff.). This remarkable convergence may only testify to the rubbery elasticity of our personality formulas which accommodate themselves to almost any sort of finding; but it may also genuinely reflect an internal consistency of personality which pervades even its seemingly most alienated states.

At any rate, it seems clear that the coercive stimulus value of these hallucinogens ought not to be overestimated. They appear to act, in a way, as releasing agents which trigger off imprinted life themes and melodies. The significant question is not *which* drug is administered, but to *whom* it is administered; individuality looms large, except in the extreme cases where sledge-hammer doses or extensive psychic disintegration may blot out its delineations. Thus, in a deviously paradoxical way, these drug experiments, which started out from organistic premises, underline the primacy of the personality.

Some investigators feel that these drug-induced states bear only the most superficial resemblance to schizophrenia, and are really nothing but another variety of "toxic psychoses" known to clinicians

for many years and "familiar to anyone who has weathered a cocktail party" (Jackson, 1962, p. 69). They hold that the observed symptoms are due primarily to the toxically induced depression of higher cerebral function, and that the mechanisms involved and the presenting picture are fundamentally different from those to be found in schizophrenia.

Increased skepticism and critical acumen have recently also been brought to bear on the body of work on tranquilizers. While it is undeniable that tranquilizing drugs have often been among the antecedents of striking changes in psychotic symptomatology, the question has now been raised as to whether these changes may not have been due largely to suggestion. Some investigations hint that patients and physicians alike may have been taken in by so-called placebo (inert substance) effects. In fact, when careful placebo controls were introduced into the experiments, the effectiveness of tranquilizers was called in question. Jackson reports a crucial study which showed that placebo and tranquilizers were equally effective in improving the schizophrenic's control of incontinence. Withdrawal of either substance was accompanied by regression in behavior, and restoration was followed by improvement again (Jackson, 1962, p. 69). These recent aspersions, which await further confirmation, may in time dampen the suggestive power (if that is what we are dealing with) of tranquilizing drugs. But for the present they remain a useful agent in helping to control the more gaudy symptoms of schizophrenia, and as such have nearly as much of a tranquilizing effect on society at large as on those directly subject to their philter-like action.

#### THE UNBRIDGED GAP BETWEEN ORGANIC AND PSYCHOLOGICAL CONCEPTS OF SCHIZOPHRENIA

If one attempts to extract a solid core of established fact from the voluminous literature on somatic factors in schizophrenia, one is left with precious little. Manfred Bleuler, in reviewing the literature, could discover only one incontrovertible finding, namely, that the range of variability of somatic indexes is somewhat greater with schizophrenics than with normals. Bleuler pointed out that even if dependable biological correlates of schizophrenia were to be found they might be consequents, rather than causes, of the disturbed emotionality. No empirical finding by itself can prove that the organic realm is more basic than the psychic one. At best, one can hope to establish a more or less precise correspondence between emotional



and bodily states. Bleuler considers the quest to establish a somatic etiology of schizophrenia as a mere chimera, and would like to replace it with work on the "physiology of emotionality" (Bleuler, 1951, quoted in Hoff, 1956, pp. 427 ff.).

Bellak, equally dissatisfied with the existing etiological theories, proposed to think in terms of a "psychosomatic multifunctional origin" of schizophrenia. But his formula is too general to be of much use. While conceding some etiological significance to organic factors, he tends to assign greater causal weight to psychological factors. Stressing the importance of faulty psychodynamic learning in the genesis of schizophrenia, he notes: ". . . it is about as likely that [schizophrenia] will be successfully prevented or etiologically treated by organic therapies as it is reasonable to expect that people will learn Spanish by injection or improve their English by taking pills" (Bellak, 1958, p. 60).

Rather intriguing vistas were opened by the attempt to use Selye's work on the General Adaptation Syndrome as a conceptual and empirical framework for research on schizophrenia. The attractiveness of Selye's formulations lies in the fact that they are based on exact physiological observations, but at the same time center around the inclusive concept of "stress" which embraces both physical and psychic agents. Selye has shown that his General Adaptation Syndrome (G-A-S), by which he means the sum of all nonspecific, systemic reactions of the subject to stress, can be produced as well by psychic as by physical stressors. Among the latter would be heat and cold, X-ray irradiation of large skin areas, hemorrhage, muscular exhaustion, lack of oxygen, and intoxication; psychic stressors would be exemplified by rage, anxiety, prolonged frustration.

Selye's concept of the G-A-S is helpful in that his notion of the functional equivalence of psychic and somatic stress shows one way of overcoming the sterile classical body-mind dualism. On the empirical level, Selye's observations suggest that the curiously diffuse somatic concomitants of schizophrenia could be interpreted as nonspecific systemic reactions to "psychotic stress"—whatever that is. To be sure, this interpretation does not account for the specific etiology of schizophrenia, but it could at least explain the failure of past attempts to find among these nonspecific factors the etiological cause of schizophrenia. If the above assumption be correct, these diffuse somatic abnormalities



would be results, rather than antecedents, of the psychotic disorder, and could be ignored in the search for etiological agencies. Such a thesis does not entitle us to consider schizophrenic disorders as a whole as a subvariety of the G-A-S, but it sharpens our eye for what may be specific to the group of schizophrenic reactions.

Another investigator, Jackson, has proposed to use communication theory—which can be described both in terms of neural events and of learning experiences—as a bridge between organic and psychogenic concepts of schizophrenia. He construes the organism in the image of an electronic computer, and makes the point that “the manner in which information is utilized by the individual will depend on intactness and adaptability of its equipment, and that his [behavioral] output will be a combination of the kind of information fed him and the way his brain utilizes it” (Jackson, 1960, p. 18). He goes on to suggest that the “range from ‘observing the output with a nonintact computer’ to ‘varying the input in an intact computer’ corresponds to the ‘organic’ and ‘psychological’ dimensions in the diagnostic system suggested above. . . . Thus, it would seem that detailed study of schizophrenia in terms of learning theories might have much to offer whether one emphasized taraxein [a metabolic product] or tension, adrenochrome or the folks at home” (*ibid.*, pp. 18-19).

It is too early to judge the success of these various attempts to construe a conceptual framework in which organic and psychological data are integrated. We do not know as yet whether Jackson’s computer image, for example, is more than just a pretty metaphor. Up to now, the great riddle of the relationship between psychic and bodily events, and of their relative etiological significance, remains unsolved.

### *The Treatment of Schizophrenia*

In the last three decades, and especially since the advent of tranquilizers and “total push” therapies, the psychiatrist’s previous feeling of complete helplessness in the face of schizophrenia has been replaced by one of partial mastery. One does not have a dependable cure for the disease, but at least one can do something about it. Many of the presently available *somatic* therapies have a very narrow empirical base, and no theoretical one whatsoever; their mode of action is unknown, no firm rationale determines their use. But they

do work, to some extent. They help to reduce and control the more gaudy symptoms, cut down the length of hospitalization, enable a patient to stay with his family or hold a job. At times, they may primarily transform the manifestations of the disease in a socially more acceptable direction, presenting us with madmen who do not affront too directly contemporary sensibilities. The prevailing social mores put high value on such feats of social control.

### SOMATIC THERAPIES

Among the modern active methods of somatic treatment the first in time was insulin shock or insulin coma therapy, introduced by Sakel in Vienna in the early 1930's. It was based, in part, on the accidental observation that an electric shock, suffered by a patient during an accident, led to a remission of schizophrenia. Sakel recognized that the intramuscular injection of insulin could be used in order to administer controlled shock or coma-like states and elaborated his method of insulin therapy which literally seemed to shock patients out of their schizophrenic state. Sakel's insulin method was shortly followed by the metrazol shock therapy of Meduna (1935), based on what later turned out to be a mistaken notion, namely, that epilepsy and schizophrenia are mutually exclusive.

Believing epileptic fits to be a contraindication to schizophrenia, Meduna set about producing convulsive seizures in schizophrenic patients by pharmacological means. In spite of its faulty premises, the method turned out to have a certain therapeutic efficacy. It was followed in turn by the introduction of electroshock therapy (Cerletti and Bini, 1938), which was easier to administer, but proved to be less effective than insulin shock vis-à-vis most forms of schizophrenic symptomatology, with the possible exception of catatonic stupors.

Since the 1930's, many additional shock-inducers have been investigated, none of which has shown a distinct advantage over the original ones.

The mode of action of the various shock treatments is unknown. What is common to all of them is that the psychotic patient is subjected to a sudden physiological insult which leads to temporary loss or clouding of consciousness; upon awakening from this comatose state, the patient may be in a more amenable frame of mind than he was before. Usually a series of such shocks are administered. Shock treatments have an unpleasant, punitive side, in which some psychiatrists see a main lever of their therapeutic efficacy. Obviously,



such a view contains a number of dubious assumptions about the nature of schizophrenic disorders.

In 1935 a Portuguese neurosurgeon, Egas Moniz, introduced the method of *psychosurgery* in the form of prefrontal lobotomy. His surgical procedure, involving the cutting of nervous tracts between the thalamus and the frontal brain lobes, was based on the observation that the lobotomization of cats tended to make the animals more placid. Freeman in this country and others picked up Moniz's lead, and enriched the arsenal of psychosurgery by additional techniques, such as topectomy, transorbital leukotomy, and cauterization of the thalamic nuclei. For a while these irreversible mental amputations, which deeply affect the personality, were performed rather freely. Nowadays they are largely discredited, being used only as a method of last resort—and many psychiatrists refuse to sanction them even as such.

Psychological observers have commented on the inhuman, vegetable-like state to which at least some lobotomized patients find themselves reduced. Freeman himself, an active proponent of psychosurgery, has noted that "on the whole [it] reduces creativity, sometimes to the vanishing point." He and Watts described their patients after major lobotomy as being "direct, practical, and uninspired" (1942). But the loss of spark is counterbalanced, in these authors' judgment, by the improvement in "social skills" which is said to enable lobotomized patients to lead an almost normal social life. Whether social adaptation deserves this high value accent seems at least open to question. At any rate, the alacrity with which these personality mutilations have been sometimes performed raises deeply perturbing questions.

As far as the new methods of pharmacotherapy by means of tranquilizers are concerned, it is undoubtedly true that their introduction has coincided with a great change in the picture presented by psychiatric wards. The more violent and repulsive forms of symptomatology—incontinence, smearing of feces, assaultive behavior—have nearly vanished. We do not know for sure to what extent the drugs themselves were responsible for this transformation, to what extent concurrent changes in the atmosphere of mental wards and of the community at large were involved, and to what extent placebo effects of a suggestive nature, based on the apparent fulfillment of magical wishes, may have been a major factor. The relative contribution of these various factors has not been established, but



the changes in presenting pictures are there for all to see, and they are impressive.

Nevertheless, much of the exaggerated optimism which greeted the advent of tranquilizers has been replaced by a more sober mood. It is widely recognized nowadays that these drugs do not cure schizophrenia in any meaningful sense of the term "cure"; their primary value lies in controlling its symptomatology. They are particularly effective in reducing catatonic excitement and extreme anxiety. In relaxing these tension states, they may bring about drowsiness and lethargy—one has talked in this connection of "chemical lobotomy"—but also tend to relax the psychic defenses of the patient, make him more open and communicative, more amenable to psychotherapy. As we have already seen, it is hard to make valid predictions about their effect on individual patients. In a review chapter, Hoch has attempted cautiously to delineate some of the conditions and limits of their efficacy: "The tranquilizing drugs are most effective in patients who have not been overtly sick for a long time. . . . [They] do not uniformly affect the mental symptomatology in schizophrenic patients, and evaluation must be made on an individual basis. A few general observations, however, are of importance. The emotional symptoms, such as anxiety and aggression, are influenced most effectively and reliably. In general, overreactions respond well. Delusions and hallucinations are also controlled quite well, and the drugs are able to reduce the emotional push behind the delusional ideas. These drugs have less effect on schizophrenic thinking and disorganization of cognitive processes . . ." (In Arieti, 1959, p. 1544). Nothing precise is known about the mode of action of these drugs.

It is possible that a sober, long-range evaluation of tranquilizers will show them not to be therapeutically much more effective than the convulsive therapies, but they are endowed with important secondary virtues: in comparison to other forms of somatic therapy, they are easier to administer and more economical in use; the risk of undesirable side effects may be somewhat less; their use does not require complicated apparatus nor close supervision by trained technicians. In short, they have in their favor all the formidable advantages of aspirin. It is true that the easy and cheap availability of tranquilizers, and the widespread yearning for pharmaceutically manufactured peace of mind, create new problems, but these are more of a social than of a strictly medical nature.

## PSYCHOTHERAPY OF SCHIZOPHRENIA

Psychoanalysis provided the major impetus for the attempt to interpret schizophrenia psychologically. However, blinded by Freud's stress on the narcissism of the schizophrenic, it also for a long time discouraged attempts at serious psychotherapy with these patients. Freud held that the self-absorption of the schizophrenic was such as to foreclose the development of a meaningful therapeutic relationship. This theoretical dictum, based on slim evidence, exerted a compelling pull on the observations of others. A readiness to believe the testimony of one's eyes was needed, and a temper impatient with dogmatic orthodoxy, in order to discover that the schizophrenic world was neither as inaccessible, as Freud thought, nor its inhabitant—and this only another way of saying the same—beyond the saving grace of therapeutic involvement. But in order to approach him, a new approach was necessary, a willingness to modify the techniques of standard psychoanalysis.

These new techniques of psychotherapy were worked out by Sullivan, Fromm-Reichmann, Knight, Rosen, Sechehaye, Benedetti, and others. The methods advocated by these authors differ from each other in important procedural details, but they all provide avenues of approach to the walled-off world of the schizophrenic. Some of them teach that it is incumbent upon the therapist to make the first step, and, if necessary, to go a long way in order to establish a meeting ground with the patient. They hold that the therapist must not tire of taking the initiative, that he must be firm and persistent in his suit, but also gentle and nonintrusive. Some therapists feel that explicit unconditional acceptance of the regressed patient's infantile needs is the best avenue of approach. They may engage in a nursing or mothering relationship with him, taking care of his bodily needs, feeding, cleaning, dressing him, or simply lending the comfort of their silent physical presence. Other therapists, such as Sechehaye, not going quite as far, prefer to deal with the patient's infantile needs on the level of symbolic satisfactions. Still others, such as Rosen, while maintaining the maternal, caretaking functions, attempt to intrude more forcefully into the patient's world. Using what sometimes amounts to psychological shock techniques, they may bombard him with "direct interpretations" of his opaque, symbolically veiled messages in order to establish, as soon as possible, a bridgehead of verbal communication.



Once contact has been established, by whatever means, some therapists are inclined to focus on the patient's infantile needs, to dwell with him in the archaic primitive world as long as necessary, that is, until the patient is ready to move out of it on his own initiative. Others, finding this waiting approach too risky and time-consuming, prefer to engage in some pulling and tugging of their own: they tend to appeal to the more mature side of the personality, in an effort to bring the patient out of the psychotic miasma as soon as feasible. Once a foothold in the shared world of rationality has been gained, more conventional methods of therapy take over. The therapeutic goal adopted is not too different from that pursued in the treatment of neurotics. But due to the infantile undeveloped personality of schizophrenics, their treatment on long stretches resembles more the procedures of child analysis than of adult therapy. Also, because of the extreme sensitivity and distrustfulness of these patients, the therapeutic road is beset with more than the usual number of pitfalls. A minor incident, such as the therapist's initiative in shifting or canceling an appointment, may become an issue of momentous proportions.

In general, schizophrenic patients are apt to make tremendous demands on their therapists, asking for more than a single human being can provide. At any rate, a therapist engaging in this sort of venture has to be endowed with unusual resources of devotion and endurance. Often it appears that it is a question of "a life for a life," that only an almost superhuman sacrificial effort can rescue the patient from the clutches of his sickness. Therapists who combine in their person the requisite resources of devotion, sensitivity, robustness, and competence are hard to come by. Even with the most sustained efforts, many years—as much as a decade—may be needed in order to effect a cure. There are some patients whose personality make-up is so fragile that they require life-long maintenance doses of therapeutic care in order to escape periodic slip-backs into the psychotic world. Other schizophrenics appear to be beyond the helping grasp of even the most devoted and expert psychotherapeutic effort. But even if it were theoretically possible to cure all schizophrenics by means of psychotherapy, it is clear that, the economics of human resources being what they are, this road would be available, in the foreseeable future, to only a small minority of those in need.

As far as the results of treatment are concerned, we know that psychotherapy has brought about cures which have been maintained



over many years of follow-up; however, there are also many cases in which the improvement wrought by psychotherapy has turned out to be short-lived. We do not know the ratio of therapeutic successes to therapeutic failures. With hospitalized schizophrenics treated primarily by somatic therapies, improvement figures have been reported which vary all the way from 22 per cent to 54 per cent of the populations under observation (improvement in this instance means all changes for the better, from relatively minor ones to complete remissions). In the majority of more recent studies, the improvement rates tend to cluster around 40 per cent. If one considers that the rate of spontaneous remissions is estimated to be about 30 per cent, these figures are not very impressive. It is too early to say to what extent the new methods of pharmacotherapy and "total push" treatment, combining somato- and psychotherapy, have made a decisive dent in these statistics. Some recent observations suggest that at least the average length of hospitalization and the rate of short-term relapses have been considerably reduced by the new methods.

We are still far from having a reliable, widely available cure for schizophrenia; we have increasingly sophisticated drugs which, while widely available, are not genuine curative agents, no matter how effective they are in controlling bothersome forms of symptomatology; and we also have psychotherapy which, while apparently able to effect genuine cures, by its very nature is restricted to a minority of the patient population. If, as some of the evidence suggests, schizophrenia is partly a supraindividual disease, reflecting pathology in small or large social units, then its incidence figures must be importantly affected by the slow transformation of social conditions (unless one assumes that the sum total of social pathology remains always more or less constant). Of course, even so-called individual psychotherapy is never limited in scope to a single individual since through him it affects the network of his human relationships. To this extent, however modest, psychotherapy becomes itself an instrument of social transformation.

# 8

## Psychotherapy

The field of psychotherapy teems with various creeds and schools, all of which proffer claims to therapeutic efficacy—often very exclusive and sweeping in nature—and whose proselytizing zeal and aspirations to universality seem to increase in direct proportion to the number of such conflicting claims. Besides the Freudian school of psychoanalysis and its various subvarieties, we encounter Jungian analytic psychology, Adlerian individual psychology, Rogerian non-directive counseling, existential analysis, dynamic and biosocial psychiatry, hypnotherapy, social-learning therapy, interactional and transactional therapy, and many others. Some approaches swear by individual therapy; other techniques require a group setting (group therapy, psychodrama, family therapy). The various approaches are, of course, of very differing coherence and depth. Some are not more than sectarian improvisations, crystallized around the figure of a minor prophet with dubious claims to originality.

Among the various psychotherapeutic schools, psychoanalysis<sup>1</sup> occupies a unique place because of the rich complexity and relative articulateness of its theoretical structure. Its therapeutic efficacy, relative to that of other approaches, is a matter of considerable controversy. But it is widely believed, and not only by Freudians, that psychoanalytic therapy is the most radical means of effecting personality changes presently available and that it is the method of

<sup>1</sup> The author designates by "psychoanalysis" those therapeutic approaches which focus chiefly on the interpersonal phenomena of transference and resistance (see below) and which use free association as a means of exploring unconscious conflict. For this definition, it is irrelevant whether or not a couch is used and whether patient and therapist meet as often as five or six times a week, as required by classical psychoanalysis.



choice for the treatment of particularly deep-rooted neurotic conditions.

Contemporary psychotherapy deals with forms of neurotic suffering different from those which were prevalent during the early days of psychoanalysis. For example, we find in a great number of contemporary neurotics as core problems the issues of personal identity and continuity, resumed in the anxious questions "Who am I?" and "Am I still today the same as I was yesterday?". These problems were unlikely to be raised in this form by the patients of Freud; their emergence undoubtedly reflects a radical shift in our societal structures.<sup>2</sup> Many present-day neurotics with their fragmented identities are much closer to prepsychotic and psychotic personalities than the neurotic patients described by Freud. In this connection, it is significant that the interest of psychotherapists has decidedly shifted, in recent times, from the classical neurotic syndromes (hysterias and obsessional neuroses) to the psychological investigation of psychotic, and especially schizophrenic, conditions. (The increased interest in the observational study of infancy and early childhood probably belongs into the same context.) This shift in emphasis and interest is likely to be not only a response to urgent social needs, but also a reflection of changes in the modal personality types of patients in need of therapy—and of the investigators themselves.

This shift in neurotic pictures, then, raises the question whether psychoanalysis in its classical form is still the most adequate of the presently available approaches to therapy or whether it must not undergo certain modifications in order to do justice to the particular forms of neurosis that ail modern man. As will become clear below, we look upon existential analysis as just such an evolutionary modification of psychoanalysis in response to new therapeutic tasks. Hence in the present chapter, we shall focus on psychoanalysis and its existentialist derivative.

Before starting on our task of exposition, it may be useful to point out that many of the presently existing therapeutic schools can be easily interpreted as truncated part-systems of psychoanalysis. This holds true most strikingly for some of the neo-analytic approaches (whose specific innovation often consists chiefly in making absolute one particular element that only had relative significance within the Freudian system). It may even hold true for apparently non-Freudian approaches such as

<sup>2</sup> On this point, see Erikson (1950) and Bally (1963).



Rogers' client-centered counseling whose spirit and technique are perhaps less radically different from psychoanalysis than its proponents (and its opponents) like to think.

### *Psychoanalysis*

In his *Introductory Lectures*, Freud formulated as the fundamental goal of psychoanalytic therapy the "making conscious of what is unconscious." This early formula still describes pretty well what analytic therapy attempts to accomplish even though, with the development of Freudian thought, its meaning has markedly expanded.

To make the unconscious conscious means primarily to lift repressed instinctual urges (id-impulses) into the realm of consciousness, that is, to subject them to the rule of the ego. To accomplish this, we need to unmask certain unconscious elements within the superego and within the ego itself. We need to expose silently operating neurotic defenses (localized in the ego) and blindly incorporated moral standards (localized in the superego), both of which oppose the emergence of repressed id-impulses. Hence we can expand our synoptic formula to read: The basic goal of analytic therapy is to make conscious, as far as possible, the pathogenic unconscious elements within the ego, the superego, and the id. This formula also defines, in a first approximation, the task of the analytic therapist. His job is that of a catalytic agent who is adept at reading and decoding the cryptic manifestations of latent psychic processes and who, unveiling bit by bit to the patient their hidden meaning, assists their gradual breakthrough into the realm of consciousness.

#### FREE ASSOCIATION

The basic procedural rule propelling the analytic process is that of *free association*, which requires the patient to talk as freely as possible about anything which comes to his mind, no matter how trivial, inane, bizarre, oafish, incoherent, or embarrassing it may seem. The goal of free association is to unfetter the subject's mind from the iron bonds of rationality which normally control its functioning and to induce a more relaxed, uncritical, dreamlike state of mind, which encourages the partial efflorescence of usually repressed psychic contents.

The task assigned to the patient is apparently very simple. He is to report whatever goes on in his mind. But, as experience has shown

and as each new patient soon finds out for himself, the seemingly easy task is in reality perversely complex and impossible of fulfillment.<sup>3</sup>

The perplexed analysand, convicted time and again by his therapist of falling short of the goal of free association, may come to feel increasingly like a prisoner bound hand and foot who is told by a sardonic jailkeeper to move his limbs freely.

The patient will not only experience continued failure in his attempts to live up to the impossible command, but he also will soon begin to wonder whether the whole procedure is not absurd and meaningless. Will an aimless wandering and meandering, at the behest of erratic, criss-crossing random thoughts, really get him anywhere? Is such foolish forswearing of purposeful rationality not bound to land him in a directionless morass of verbal incoherence?

Such misgivings are natural, but unwarranted. It soon turns out that the apparently aimless, rambling verbal utterances of free association have a directionality and a syntax of their own, which does not conform to the rational canons of ordinary speech but is determined by an *emotional* logic. It is easy for the analyst to show that apparently random thoughts, tossed off according to the rules of free association, fall, as if by magic, into distinct thematic configurations, that they are constellated in clearly discernible patterns like iron filings under the sway of a magnetic field. The invisible magnet, in this case, is an unconscious psychic complex.

The thematic patterns which emerge during the process of free association sometimes display the intricate architecture of a symphonic piece of music. The listener registers with wonder the slow emergence, articulation, and amplification of a given theme which, after reaching a certain degree of sonority, all of a sudden vanishes, only to reappear after a while, perhaps transposed and disguised, but unmistakable as to its essential identity. The experienced clinician can often guess after the first few "bars" in which direction the associative composition is moving. An overly simple, but didactically useful example is that of a patient who told her doctor during the analytic hour that she had gone to a restaurant to dine. The carpets had been red; she had noticed bowls of gooseberries or raspberries on the tables; she had been in a rather bad mood that day, and so on. Her analyst, struck by the importance assigned to the color red in

<sup>3</sup> The reason for this difficulty will become apparent below, in the section on "resistance."



her associations, inquired whether she had not had her menses at that time. She replied that she had indeed been preoccupied that day with a difficult menstruation.<sup>4</sup>

Patients differ greatly in their natural ability to produce a plausible facsimile of free association. Many obsessives, in particular, are pathetically constrained in their verbal productions, finding it well-nigh impossible to abandon the rigid canons of super-rationality. Their grammar is forever stiffly correct, they show a gooey tendency to stick to the point, they are restricted in their choice of topics, and their transitions from one theme to another are seldom smooth. Their talk has the earmarks of a rehearsed "literary" production and resembles nothing as much as a term paper, written around an assigned topic, by a plodding, grade-conscious college student.

A case in point is that of a young lawyer who went into therapy because he could not make up his mind whether he should marry the girl with whom he had been going on and off for a number of years. Throughout the first therapy hours, he talked almost exclusively, in a lawyer's systematic way, about the pros and cons of his contemplated marriage. After some rapport had been established, the therapist pointed out how insistently the patient stayed with this one, self-assigned topic. Therapy started only to move when the patient became daring enough to venture into different, seemingly unrelated areas, which little by little illuminated his anxieties about getting married.

Contrary to the overly controlled obsessive and depressed types, many hysterics seem to take to free association like the fish to water. They may talk a mile a minute, apparently very loosely and spontaneously, with all the lack of tight logical coherence the most anti-Aristotelian analyst could wish for. However, they only mimic free association. Closer listening discerns a certain flighty, contrived, mechanical quality of their stream of talk, which reveals it for what it is: a verbal smoke screen which attempts to conceal the periodic intrusion, however fleeting, of disturbing thoughts or emotions.

Cameron and Margaret offer a brief excerpt from the protocol of a patient who was already well-practiced in the technique of free association. The patient was a young man suffering from severe chronic anxiety and from a specific phobia of high places. His fears were related in intricate ways to sexual confusions, feelings of inade-

<sup>4</sup>This example is cited by Dalbiez (1941, II, p. 97).



quacy, and repeated failures to attain his vocational goals. His associations during part of a therapeutic hour went as follows:

The same thing applies to the fact that they told me some time ago about loss of sleep in the beginning of the night or the last part of the night and I insisted the first was. . . . I noticed for two or three nights I began waking up at 2:30 and laying awake most of the night . . . or semi-conscious . . . two-three nights . . . is that done because I'm a creature of habit on account of the suggestion of my mind . . . or am I with a nervous disease. (Pause) Thought about nearly everything . . . in general—can't recall it—nothing relating to sex . . . tried to put it out of my mind and I fight to keep it out. Got the habit of thinking about things and would dream about them . . . tried to keep things out of my mind . . . like fighting on account of the past. My mind traced right on through these lights to the fifth floor and a blonde woman . . . shows my mind runs on to sex and injury . . . things like how to avoid going up in high buildings . . . afraid of how high I'd go. Didn't want to tell anybody what my trouble was. Saw it was only a four- or five-story building so I consented. It didn't bother me . . . didn't seem a real test because it wasn't high. Still no confidence in myself . . . still in the dark as to my conflicts . . . two things, one "yes" and one "no." Decided I'd adopt the good because the bad was lashing me. . . ." (Cameron and Margaret, 1951, p. 571).

This short excerpt illustrates the loose, dreamlike, apparently disconnected quality of free verbalizations, and the repeated shifts between various levels of control. At times, the patient seems to surrender almost totally to the tide of thoughts and feelings welling up in him, then a more critical, appraising, "objective" attitude intervenes ("shows my mind runs on to sex and injury . . ." or "still no confidence in myself . . ."), usually at points where it is fairly clear that anxiety is on the increase. The reader will also notice, in this small sample of associative tissue, the emergence and the weaving together of several crucial themes: his concern with high places and sex and injury ("fighting about the past . . . the fifth floor and a blonde woman . . ."), his uneasiness about "how high" he should go, his apprehension about being "tested." His rational mind seems to recognize, however dimly, connections between some of these elements: "Shows my mind runs on to sex and injury. . . ."

What amounts almost to a parody of free association is offered by the more outlandish utterances of schizophrenics whose talk may string itself along, for considerable stretches, by mere verbal "clang," feeding on inane or, sometimes, wildly inventive puns, which are seldom devoid of deeper meaning. Thus a desperate young schizophrenic patient of Laing (1960, p. 211) called herself during one

period of her illness "Mrs. Taylor." She was asked what the name meant. It meant "I'm tailor-made . . . I'm a tailored maid; I was made, fed, clothed, and tailored." This psychotic girl managed to compress, within the nutshell of a single name, a long catalogue of passionate grievances against her mother.

#### INTERPRETATION

Psychoanalytic therapy institutes a radical division of labor. The patient is encouraged to suspend, for long stretches, the critical, evaluative, rational functions of his mind and to become a mere producer of unsifted verbal material. The rational, observing, appraising function devolves upon the analyst who in a way acts as a substitute ego—not unlike a heart machine which, during a critical phase of surgery, takes over from the patient's organ. This temporary relief from the burden of self-protective vigilance is meant to free the patient to become more spontaneous and productive.

The basic task of the patient is to supply raw "verbal material"; that of the therapist, to listen—and to comment at certain critical junctures. Such comments of the analyst are usually few and far between. Much of the time, the analyst is just a silent presence. His role has been compared to that of the life guard who as long as all goes well remains inconspicuous, but comes to life as soon as a swimmer gets into trouble. When the patient's anxiety becomes unbearable, the analyst will take over and reassure him. Such rescue operations, however, are only one, and usually secondary, aspect of the therapist's job.

The therapist's abiding silence in itself is a powerful therapeutic agent. It assures the patient's freedom from irksome intrusions. It creates a free space which draws the patient out, allowing his words to linger and reverberate, and thus to gain a peculiar resonance. In this free space staked out by the analytic setup, the neurotic's speech at the same time reveals its exaggerated defensiveness and may venture to dispense with some of it. Thus language, the spoken and shared word, regains its dignity as the "house of the psyche" (Heidegger), as a primary vehicle of self-expression and self-realization.

The pregnant, therapeutically inspired silence of the analyst tends to give a peculiar weight to his rare verbal utterances. These either aim to reassure, as we have already seen, or they want to illuminate by confronting the patient with up-to-then ignored parts of himself. Comments on the therapist's part which are meant to expand the



patient's self-knowledge are called *interpretations*. They are considered by psychoanalysts as their most direct and effective therapeutic tools. They are the analyst's active contribution to the making conscious of the unconscious.

Expert interpretations may have far-reaching psychic effects; they may put into question the patient's most axiomatic assumptions about himself and his world, and, in bringing about a partial collapse of his old self, will beckon him to find a new identity.<sup>5</sup>

Interpretations are of varying degrees of penetration and depth. In particular, during the early stages of therapy, they may be no more than superficial hints which slightly reformulate the patient's own statements.

Thus toward the end of his first therapeutic hour, a patient asked the therapist what he thought of him. The patient had given various behavioral indications of feeling anxious and under strain. He had talked mostly about day-to-day activities, in quite stereotyped terms, except for the brief mention of a fragment of a dream in which a bomb had gone off. The patient had also alluded to a "rather charged" situation at work. To the patient's urgent query what the therapist thought of him, the latter replied that something potentially explosive seemed to be threatening the patient from without or within. During the next session the patient said that he did not know why, but he had felt greatly helped by the therapist's simple comment.

At a later stage in the treatment of the same patient, the therapist found occasion to make a more pointed interpretation:

The patient whose earlier anxiety had been replaced at that point by feelings of depression reported a dream in which he found himself in a barbershop. His hair was being clipped by a stout, tough-looking, "beer-filled" barber who used an odd, drill-like cutting tool. The barber was cutting the hair very short as the patient had desired him to, but in doing so he kept looking at a large clock. He seemed to be "cutting by the clock." When the work was finished the barber said that the charge was five

<sup>5</sup> Interpretation, if wrongly used, can become a tool of indoctrination in the service of a therapist's need for self-aggrandizement. It may also be used defensively by the analyst in order to lower the emotional temperature of an interpersonal situation getting too hot for his comfort. Sometimes, the analyst's interpretative pronouncements will not only tend to defuse raw emotions, but also to mythologize their ideational counterparts. The patient, in trying to emulate the mental acrobatics of his analytic mentor, loses his chance at self-revelation.



dollars. The patient protested against this exorbitant price, but the barber insisted that this had been a very special haircut and became rather threatening. After a while, the dreamer relented and forked out a five-dollar bill whereupon the barber became all smiles and said that the patient was "the nicest guy in Delaware." The patient remembered grinning sheepishly about this ambiguous piece of flattery.

The dream did not make much sense to the patient. It reminded him of an incident during a vacation trip to Germany where he had omitted to tip a toilet attendant who had gotten extremely angry and had shouted in guttural German "raus!" The barber also reminded him of a taciturn mechanic who would just fiddle around with a few bolts and then present a stiff bill without the patient being sure whether his services really had amounted to anything.

At this point, the therapist suggested that the barber who was "clipping the patient by the hour" was really linked in the latter's mind with the therapist. The patient seemed genuinely surprised and demurred at first, but then came up with a wealth of confirmatory details, among which were the therapist's German accent, his prominently displayed clock, his recent raising of the therapy fee, and his having presented the patient the day before with a substantial monthly bill. The patient had not protested and had not even felt anger at the raising of the fee, but had "acquiesced sheepishly." He then proceeded to talk about "flashes of irritation" about other matters of which he had had glimpses for some time but which he had carefully concealed, and among which his annoyance at being "cut short" at the end of the hour was prominent. The patient next began to question in cogent terms his habitual attitude of smiling acquiescence which he linked with his "paying bills to [his] unconscious," that is, with his attempts to assuage his massive feelings of guilt which of late had begun to creep into his consciousness.

By articulating the patient's latent feeling that he was being clipped by the hour—which the dream had expressed so graphically—the therapist freed him to give vent to accumulated grievances and then to go on and seriously question a rigid character trait (acquiescence) which up to then he had taken pretty much for granted.

The above interpretation, which linked the overcharging barber

and the silent mechanic of dubious competence with the therapist, was undoubtedly useful, but it was not very "deep" by the analyst's standards. Many psychoanalysts take a great delight in penetrating to what they take to be the most archaic layers of the patient's mind and in exorcising, by the spell of interpretation, the evil spirits dwelling in the unconscious depths. We have already encountered an example of such spell-binding in Mitscherlich's bold interpretation which connected a young man's tubercular cavern with his unconscious fantasies about being impregnated by his father (see Chapter 5). However, there is no necessary correlation between the "depth" of an interpretation and its therapeutic efficacy.

One of the most important aspects of the work of interpretation is "timing." An interpretation, no matter how correct, may remain ineffective, or, worse yet, may lead to a hostile withdrawal of the patient if it is not made at the right time. What is the right time? When the patient is ready. When is the patient ready? When his associations and his behavior indicate that the formulation to be propounded by the therapist is almost within his grasp, is near the point of emerging, as an articulate insight, to the surface of his consciousness. (We shall see below what additional factors enter into play here. See the section on resistance.) A premature interpretation shows that the therapist has not accurately sensed the state of affairs, and the patient may react to it as to an assaultive act, especially if it is offered with any insistence. Otherwise, in the more favorable case, he may simply ignore it, and the therapist's misstep may remain without visible effect, except perhaps for a slight injury to his *amour-propre*.

Many interpretations, especially those attempting genetic reconstructions, are highly speculative. The question arises as to how one judges their correctness (validity). For some analysts, it is the patient's reaction which is decisive. It is not so much his conscious assent or dissent—neither of which, as experience has shown, is to be trusted—but rather his general behavioral response to the stimulus of the interpretation. If strong affects, positive or negative, are stirred up, which may betray themselves by disturbances of the associative process; if unusually rich, up-to-then buried associative material begins to gush forth; or if the stream of association ebbs and sputters or even comes to a complete standstill as a consequence of the interpretation, then many an analyst will be inclined to conclude that he has hit home. It ought to be clear that this pragmatic criterion is far



from being logically unassailable, that an interpretation may be off the mark, and yet set in motion powerful affects (be they only feelings of anger at the therapist's heavy-handed clumsiness).<sup>6</sup>

The material produced by the patient may be very abundant. Theoretically, everything the patient says or does is grist for the mill of interpretation, but in actual practice some of the material is more promising than the rest. The original Freudian preference for dream material, which allegedly expressed most directly the aspirations of the unconscious, is well known. Later on, when the emphasis shifted toward an unmasking of neurotic defenses, more "superficial" material was favored. But whatever the theoretical focus, a question of selection arises. Out of the vast amount of material generated by the normally loquacious patient, what is the therapist to pick for his attention? Some sort of choice will obviously have to be made. On the basis of what criterion? Haltingly at first, and then with increasing assurance, as psychoanalysis discovered its own essence, it came to focus on the immediate interpersonal phenomena which it called transference and resistance.

#### RESISTANCE

The history of psychoanalysis is a history not only of stumbling blocks overcome, but also of stumbling blocks turned into cornerstones. Originally, Freud conceived of psychoanalytic therapy as a relatively smooth undertaking not much different from hypnosis in the image of which it had been fashioned. The patient—so Freud thought—had only conscientiously to follow the basic rule (of free association) and pour forth his uncensored material; the analyst, expert in reading the symbolically coded language of the unconscious, would be enabled to draw the necessary conclusions about the nature of the pathogenic conflict, and to communicate his insights, after appropriate preparation.

But soon Freud was to make the disconcerting discovery that his patients were unwilling or unable to live up to the apparently simple basic rule. Far from reporting everything which went through their mind, they apparently engaged in all sorts of maneuvers of evasion and dissimulation, betraying themselves by telltale signs, such as sudden obstinate silence. When taken to task for their infraction, they would not disdain to fall back upon the most threadbare excuses.

<sup>6</sup>A more dependable criterion is that of external validation, for example, the confirmation of the correctness of a historical reconstruction by the testimony of a trustworthy third person.



They would act as if they had never heard of the basic rule, or as if the analyst could not possibly have expected them to take it seriously. They would say that what they had been thinking of was patently too absurd, or too irrelevant, or too embarrassing for them to mention it, or that by communicating it they would betray the confidence of others. If the analyst insisted that the injunction to tell everything really meant what it said, they might reluctantly part with the withheld chunk of material (which more often than not turned out to be highly relevant), only to engage again, shortly thereafter, in similar attempts at concealment.

Freud was taken aback at first at this apparent perverseness of his patients, but gradually came to recognize that their infractions of the basic rule were unavoidable; in fact, he realized they were the manifestation of a formidable psychic force—a force as powerful as that which had caused the original pathogenic repressions. Freud gave to this negative force which seemed bent on keeping the lid on, and on counteracting the therapist's efforts, the name of "resistance." Once the ubiquity of resistance had been recognized, it became clear that nobody—and especially no neurotic—can live up fully to the rule of free association; neurosis means precisely the lack of transparency, to self and to others, which manifests itself as interference with the flow of communication. To become undefensive and trusting enough to tell all, even the faint stirrings of thought and emotion at the borderline of awareness, is tantamount to being nearly cured. The progress in the ability to free-associate becomes a measure of the therapeutic advance. The method of delivery turns out to be the delivery itself.

Resistance can take many forms. It may manifest itself as polite assent or cool indifference, as silence or overtalkativeness, as stickiness and repetitiousness of speech or as disorganized rambling, as psychologizing or intellectualizing, as a dearth of material or a plethora of it. Resistance may take the form of omission of pertinent details, of forgetting and canceling appointments, of being late for the therapeutic sessions or of neglecting to pay the therapist's bills. All these forms of resistance are of great concern to the therapist since without their neutralization by analysis further therapeutic progress is impeded. Of particular importance are those forms of resistance which affect most directly the emotional climate of the therapeutic relationship, for example, feelings of dislike, anger, embarrassment, shame, or guilt clearly centered around the figure of the therapist. This variety of resistance is termed "transference resistance" or "negative

transference," and it is given priority among the phenomena singled out for the therapist's intervention.

#### TRANSFERENCE

To the extent that psychoanalysis discovered its essence as that of a therapeutic encounter between two human beings, the interpersonal phenomena of transference came to occupy the focus of its attention. Transference, according to Freud, is a "universal human phenomenon"; it refers to the tendency to carry feeling residues from past relationships into new encounters, to make them the basis for the perception of the new situation. The neurotic person is particularly prone to react to new partners in the light of old experiences, treating them as if they were merely a re-edition of significant figures of the past. This element of stubborn, and usually unconscious, repetitiveness, impervious to the changing realities of interpersonal situations, is what the analyst means when he talks of transference.

Colby offers a simple example illustrating the difference between transference and appropriate emotional reaction: "... if the therapist openly insults the patient until he becomes angry, then the anger is not a transference but a normal emotional response appropriate to the situation. But if the patient is enraged because the therapist wears bow ties, then the disproportionate and inappropriate response signifies the presence of a transference" (Colby, 1951, p. 107).

The main task of the analyst consists of bringing home to the patient time and again, using the events during the analytic hours as prime examples, how these transferred emotional reactions, which spring from unassimilated childhood experiences, distort his interaction with others. The emotional blandness of the analyst ("analytic incognito") which offers very little realistic support for the affective reactions of the patient, is meant to reveal, with particular clarity, the archaic, absurdly disproportionate nature of these reactions.

As the therapeutic relationship deepens and the figure of the analyst gains in emotional significance, he is wont to draw upon his person the patient's unliquidated affects surviving from the period of his childhood. Because the analytic situation partly reinstitutes the situation of early childhood, with the far-reaching dependency of the patient on the therapist, it is bound to mobilize with particular vehemence the attitudes rooted in the infantile past. This mobilization occurs in a peculiar manner: Instead of remembering them, the



patient re-enacts ("acts out") these infantile attitudes (for example, attitudes of stubborn negativism), usually unaware of what he is doing.

The way in which the analyst deals with the transference determines more than anything else the success or failure of therapy. The analyst tries to dissolve the transference attitudes by connecting them with specific memories and tracing them back to their infantile origins. With untiring persistence, he attempts to convince the patient that his intense emotional reactions are "in reality" not meant for him, their apparent object, but are revenants from the past which have lost the mooring to their real object and poison the patient's present with the curse of sterile repetition. Release comes about when blind re-enactment is transformed into conscious recollection. The overcoming of the transference resistance, Freud says, involves

a permanent alteration in [the patient's] mental economy. The transference is made conscious to the patient by the analyst, and it is resolved by convincing him that in his transference-attitude he is *re-experiencing* emotional relations which had their origin in his earliest object-attachments during the repressed period of his childhood. In this way the transference is changed from the strongest weapon of the resistance into the best instrument of the analytic treatment. Nevertheless its handling remains the most difficult as well as the most important part of the technique of analysis (Freud, 1925, SE, Vol. XX, p. 43).

If analysis proceeds in a regular manner, sooner or later a curious phenomenon arises. The patient seems to be largely free from the symptoms and complaints which originally brought him to the therapist—he seems to be cured. But any attempt to dismiss him at this point will produce a recrudescence of his former symptoms. His cure was less real than apparent, his freedom from symptoms being contingent upon his maintaining a relationship with the therapist. His original neurosis has been replaced by a less visible, "artificial" neurosis—a so-called transference-neurosis.

The therapeutic task, then, during this last phase of the analysis consists in dissolving the transference neurosis, and thus freeing the patient from his dependency on the therapist. The transference has created "an intermediate region between illness and real life through which the transition from the one to the other is made. The new condition has taken over all the features of the illness; but it represents an artificial illness which is at every point accessible to our intervention" (Freud, 1914, SE, Vol. XII, p. 154).

Analysis assumes that the real factor which promotes the patient's improvement during the stage of the transference neurosis is his love



for the therapist; he gets well because he wants to please his analyst. Then it remains for him to be "cured" from this transference love. The analyst has the delicate task of making it clear to the patient that the psychoanalytic situation by its very nature does not allow the full reciprocity of love between equals for which he longs, that he must detach himself from the analyst and seek the realization of his love needs with another human partner. Hence the analyst demands from the patient a piece of conscious renunciation—a sacrifice the latter had not been able to accomplish in relation to one or both of his parents. In order to bring off this delicate task the analyst ought to model his feelings "on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (Freud, 1912, SE, Vol. XII, p. 115).

In order to maintain this "surgical" detachment, it is necessary for the analyst to recognize in himself, and to master, all the distorting and tempting forces of his own emotional involvement with the patient ("countertransference")—all desires for domination, no matter how subtle in form, all attempts to fashion the patient in his own image, all claims on a return of love and affection on the patient's part, all erotic desires and ambiguities which could derail the situation in a sexual direction. If the therapist allows himself any liberties along these lines, he and his patient are likely to get stuck in the complicity of an inextricable mutual dependency relationship which bars the avenues to complete cure.

It is also incumbent upon the therapist to amalgamate his determination not to be swayed from the right road with a large dose of sympathetic patience. It would not do for him to attempt and force the issue of the patient's emancipation by artificial means, such as the premature setting of a termination date for therapy. The slow process of psychological maturation does hardly allow for ingenious short cuts. The therapist who tries to short-circuit the repetitive and laborious process of "working through," of examining again and again from successively varying angles, the crucial psychological issues does not bestow a favor on his patient. He risks, on the contrary, perpetuating his neurotic bondage.<sup>7</sup>

<sup>7</sup> This comment applies also to various systematic attempts to shorten standard analysis, notably F. Alexander's (1946). Such attempts may be valuable insofar as they promote a greater flexibility of approach, but their struggle for maximum efficiency per unit of time tends to be self-defeating. It is the notion of maximum efficiency itself which is incommensurable with the spirit of analytic therapy.

## SOME INNOVATIONS IN PSYCHOANALYTIC TECHNIQUE

Since the publication of Freud's papers on psychoanalytic technique, various attempts at modification and innovation have been made. Most of these attempts, whether undertaken by orthodox analysts or by professed deviationists (neoanalysts), were already foreshadowed in Freud's writings. They were more in the nature of changes of emphasis than of radically new departures. The major yield of four decades of technical controversy has been an increase in flexibility which has enabled psychoanalysis to extend considerably its field of clinical application. Let us examine briefly some of the focal points of technical innovation.

One major focus of concern has been the relative therapeutic efficacy of intellectual insight as opposed to emotional abreaction. There has been considerable moving to and fro in this respect since the days of the early cathartic method of Breuer and Freud. Since then, Freud's increasing emphasis on intellectual enlightenment ("insight") has exposed psychoanalysis to the risk of degenerating into a futile mental acrobatics without deep emotional resonance. Hence the periodic endeavors (by Ferenczi and Rank in the 1920's and by Alexander in the 1940's and 1950's) to re-establish the primacy of emotional impact ("corrective emotional experience," Alexander).<sup>8</sup>

Even today it remains a moot question whether intellectual insight is the precondition of emotional release or whether, inversely, a partial emotional abreaction is the prerequisite for significant insight to emerge. We are here probably in the presence of one of those circular processes where it is nearly impossible to assign a definite starting point. It seems clear that both elements are needed, and that their optimal combination will vary from case to case. Thus, in the case of an obsessive intellectualizer, one may be wary of exposing him to heavy doses of intellectual interpretation for fear of playing into his defenses rather than undermining them.

Another point of contention is whether therapeutic attention ought to center on the repressed instinctual urges (*id analysis*) or on the defense mechanisms and neurotic character traits (*ego analysis*). In recent decades, the trend has been quite clearly toward an increased emphasis on ego analysis. Psychoanalysts have become less bent on ferreting out lost childhood memories or on interpreting the unconscious fantasies revealed by dreams. Instead, they are more apt to

<sup>8</sup> This emphasis was taken up and developed later on by existential analysis (see below).



scrutinize bits of fantasy or behavior which highlight the patient's defensive strategies. In the context of ego analysis, much effort has been spent on studying the internal structure of the ego, and of the sphere within it which is said to be "conflict free" (Hartmann, 1958).

But the phenomena most closely scrutinized by analysts and neo-analytic reformers alike were those of transference and countertransference. The question was debated whether it was possible and useful to manipulate the intensity of the transference relationship in order to achieve optimal therapeutic effects. Alexander (1954, 1956), abandoning the notion of the psychoanalytic incognito (the therapist as a "blank screen"), advocated that the analyst bring his personality into play in a deliberate way. This meant that the analyst was to replace his spontaneous (countertransference) reactions with consciously planned attitudes adapted to the specifics of a given therapeutic situation. For example, by taking an attitude toward a patient diametrically opposite to the parental attitude which had a pathogenic effect, the likelihood of fostering a "corrective emotional experience" was increased.

Another variable subject to manipulation was the frequency of therapeutic interviews. By reducing this frequency or by interrupting therapy, for instance, the analyst might bring into the open exaggerated dependency reactions on the patient's part, which otherwise might have remained unconscious. A number of analysts objected to these efforts at manipulation on the grounds that they were contrary to the spirit of psychoanalysis. However, E. Bibring (1954) pointed out that a certain amount of manipulation is part of any psychotherapeutic procedure, including psychoanalysis. It is logical that those interested in shortening the duration of analytic therapy advocated modifications of technique tending to avoid the development of a full-fledged transference neurosis.

Its greater flexibility of approach has enabled psychoanalysis to widen its scope of effective intervention. In the mind of its founder, psychoanalysis as a therapeutic method was to be restricted to the treatment of the classical symptom neuroses—anxiety states, obsessional, hysterical, and phobic syndromes. He felt that the state of affairs in severe depressions and the major psychoses was such as to preclude the formation of dependable transference ties and hence the accomplishment of solid therapeutic work. But in the last decades, psychoanalysis as modified by Fromm-Reichmann, Sullivan, Knight, Rosen, Secheyane and others, has not only shown its mettle in the treatment of psychotic—and especially of schizophrenic—reactions,



but also has extended its scope of successful application to borderline (prepsychotic) states, character and behavior disorders including sexual perversions, and psychosomatic conditions. This is not to say that psychoanalysis is invariably successful in the treatment of these conditions—therapeutic failures and half-misses are no rarity—but only that some of its practitioners have successfully treated a number of cases falling into these categories.

### *Existential Analysis*

Psychoanalysis has found a contemporary extension in the school of existential analysis which radically questions the philosophical assumptions underlying Freudian theory, but which discovers in Freudian practice the seeds of a new “existential” understanding of man. It was Ludwig Binswanger (1947), in particular, who made explicit the positivistic-physicalistic axioms underlying Freud’s ideas about the nature of man and the structure of reality. Taking Binswanger’s critique as his point of departure, Medard Boss (1963) has attempted to show that psychoanalysis is rent by a fatal internal contradiction. Boss contends that Freudian theory is at odds with the empirical observations of Freud. Discarding the theoretical superstructure of psychoanalysis, for which he has little use, Boss discerns the existence of a providential affinity between Freudian psychotherapy and Heidegger’s metaphysics. He goes so far as to suggest that Freud, the psychotherapist, was an unwitting existentialist whose historically conditioned theoretical prejudices alone prevented him from realizing the full philosophical import of his discoveries (Boss, 1957). The same theme of Freud’s latent existentialism is also sounded, more lightly, by Bally (1961). This Freudian analyst has managed to write, seemingly without doing violence to his material, an “Introduction to the Psychoanalysis of Sigmund Freud,” which reads on long stretches like the preface to an (as yet unwritten) treatise on existential analysis. Hence it is wrong to think of existential analysis as an originator of new psychotherapeutic techniques; its contribution in this regard has been negligible. It is content, for the most part, to use the old Freudian techniques (free association, interpretation of transference and of dreams), but it strives to provide a philosophical foundation for their use, it employs them in the pursuit of different therapeutic goals, and in the process subtly changes their meaning.

The key to the understanding of existential analysis as a therapeutic approach is provided by the history of its clinical origins. As a clinical

discipline, existential analysis derives from the phenomenological studies by Ludwig Binswanger (1945, 1946, 1949, 1952) of the world of the schizophrenic—case studies executed with so much loving care in the description of minute clinical details that they have been compared to Dürer paintings. It so happened that these studies were published at a time when the once relatively solid world of the neurotic showed more and more features of psychotic-like de-realization, especially in the increasingly frequent neuroses of boredom and emptiness, in which some want to see the prevalent form of neurosis of the near future. Hence the new insight into the psychotic mode of being gained by Binswanger and those influenced by him (Boss, Bally, Benedetti, Storch, Wyrsh) came to be of increased relevance to the understanding and treatment of contemporary neurotics.

As we have seen, existential analysis interprets psychosis as the revelation of a blatant miscarriage of self-realization. In the psychotic symptoms, particularly in visual and auditory hallucinations, the rejected and denied potentialities of being protrude themselves, at last, into the phenomenal field of the patient, and they do so with such overpowering and shattering an impact that he can no longer doubt their reality (no matter how assiduously his environment strives to exorcise them as unreal). It is true that these unheeded existential concerns, the neglect of which is said to be the ultimate root of the pathological sense of inferiority and guilt, emerge in psychosis in such a grotesquely distorted form that their real meaning is not easily understood and is in need of therapeutic elucidation. As for the neurotic, he lives under the shadow of a similar, but more successfully ignored, existential debt which, again denatured, makes itself felt in the petty phobias, singular scruples, and feelings of boredom which poison his life.<sup>9</sup> But whereas the psychotic is exposed to the naked dread of immediately experiencing the denied realities, the neurotic manages to fool himself about the degree of their substantiality. He pays them only the indirect compliment of looking the other way.

Of most direct therapeutic relevance has been the redefinition by existential analysis of the interpersonal phenomena which psychoanalysis calls transference and resistance. Whereas psychoanalysis emphasizes the intrusion of the past, the element of repetition, in the emotional reactions of the patient to the therapist (subtly deprecating their reality by the use of the antiseptic label of "transference"), existential analysis sees a "communicative *novum*" (Binswanger, 1947,

<sup>9</sup>In a way, the neurotic's relative success in silencing the rejected parts of his personality is a misfortune; it delays the coming to grips with his crucial life tasks.



Vol. I, p. 142) in the confrontation of this particular patient with this particular therapist. Also it stresses the unique features, the concrete "here and now" of this relationship which it designates as "encounter" (see F. J. Buytendijk, 1950). Binswanger articulates some of the implications of this shift in emphasis:

When [psychoanalytic] therapy fails the analyst is inclined to assume that the patient was unable to overcome his resistance against the physician as father image. But the decisive factor with respect to the therapeutic efficacy of an analysis is frequently not whether the patient can overcome the resistance against the father image projected onto the physician, thus becoming free and independent, but whether he is able to overcome his resistance against the father with *precisely this* physician; in other words, whether the rejection of this physician as a human being, the impossibility of entering into a genuine communicative relationship to him, was not the impediment to the overcoming of the "eternal" repetition of the resistance against the father (Binswanger, 1947, Vol. I, pp. 142-3).

This emphasis on the urgent immediacy of the "dialogue" (Buber, Trüb) between patient and therapist is bound to reflect on the conception of the role of the latter. In existential analysis, the therapist is no longer allowed to hide behind the fiction of his emotional neutrality. He has to shed his "analytic incognito," revealing without affectation his own personality, and becoming, to the extent that the infantile needs of the patient require it, an active caretaker. The abandonment of the pose of detached passivity was first forced upon the analyst by the desperate appeal of the schizophrenic patient, but the neurotic equally craves the therapist's active intervention. This is illustrated by the fact that in the (orthodox) psychoanalytic treatment of neurotics the first signs of "positive transference" usually appear after "the analyst has made his first insight-producing interpretations with their resulting emotional effects on the patient" (Bally, 1958, p. 150).

Existential analysis has also re-evaluated the meaning and therapeutic handling of dreams in which it recognizes the emergence of previously denied modes of existence and the putting into question of the too narrowly construed reality of waking life (Bally, Boss, Siebenthal, Storch).

Finally, there is the existentialist attempt to redefine therapeutic goals, in terms of self-finding and self-realization (Storch, Benedetti), in terms of feeling securely rooted in the ground of existence (Dürckheim), in terms of being ready to assume man's inescapable burden of anxiety and guilt, in terms of becoming ripe for the "dual



mode of existence" (Binswanger, Trüb), in terms of learning to apprehend oneself "as a light emanating from the mystery of existence, in whose rays all things and fellow-beings are allowed to appear and unfold according to their own nature" (Boss, 1958, p. 119).

A case illustrating the "daseinsanalytically"<sup>10</sup> modified treatment" of a neurosis with psychotic interlude is presented by Boss:<sup>11</sup>

The patient was a physician, aged thirty-two, of middle class background, single, without religious affiliation. As far back as he could remember, he had been dogged by severe and unremitting feelings of guilt which had made his whole existence a continuous chain of self-punitive and self-destructive acts. He had already undergone, from his twenty-fifth to twenty-eighth year, an orthodox Freudian analysis which altogether amounted to four hundred and twenty therapy hours.

In the course of this analysis, free associations and dreams pointed with all desirable clarity to the existence of a crass Oedipus and castration complex. The patient reported many dreams involving sensual relationships with maternal figures, several times with his actual mother. Each time punishment ensued at the hands of paternal figures aiming at the wanton destruction of typical phallic symbols. Neither the dreamer nor the therapist could avoid the conviction that the self-destructive acts of his waking life merely served as an attempt to soothe his guilt feelings and castration fears.

As therapy progressed, the patient dreamt with increasing frequency about lofty Gothic church towers. In one dream, for example, he found himself on the ground floor of a church tower of this sort; an old man, who clearly resembled a former anatomy teacher of his, wielding a curious knife-like tool of gigantic proportions, was striking at the foundations of the tower in an effort to topple it and to bury the dreamer in the rubble. The destructive tool appeared to the dreamer as a tremendously enlarged version of the dissecting scalpels he had used during the first semesters of his medical studies.

Although the patient, under the cautious guidance of the therapist, learned to see the church towers of his dreams as phallic symbols, and figures like the knife-wielding anatomy instructor as symbolic disguises of a castrating father, his psychic health did not perceptibly improve. After three years of analysis, nothing had really changed, neither the dreary monotony of his dream life, nor the stereotyped character of his waking life, nor his chronically morose mood.

Sometime during the fourth year of treatment, the patient decided to switch therapists. This decision by itself led to a temporary alleviation of his guilt feelings. The new therapist was of Jungian persuasion. He used a different approach to dreams. For example, he was willing to see dream churches as religious images, without reducing them right away to sexual symbols. He tried to convince the patient, with the help of many mytho-

<sup>10</sup> Boss designates his own brand of existential analysis as "Daseinsanalysis."

<sup>11</sup> This case is reproduced in a condensed, partly paraphrased version.

logical and anthropological illustrations, that such religious images are the expression of a primordial "psychic function," and that they contain not less "psychic reality" than sexual fantasies. The patient listened carefully, avidly imbibing the new knowledge about "archetypal structures" offered to him, but in spite of his own and his therapist's serious exertions, his psychic malaise refused to yield. This time it was the therapist who, after two years, took the initiative in ending treatment. He told the patient that he had taught him everything in his power to teach, and that henceforth he ought to consider himself as normal.

The patient tried hard to live up to the doctor's pronouncement, but with meager success. He felt as guilt-ridden, lacking in direction, and empty of feeling as before. Moreover, he began to develop obsessional symptoms. He would spend hours cleaning and polishing precious crystal glasses, which he had started collecting as a hobby, and showed other signs of a rampant cleanliness fanaticism. His clothes had to look ever more immaculate; he was compelled to wear a pristine white handkerchief at all times.

It was despair which, after an interval of two years, drove him to a third therapist—this time (as the reader may have guessed) an existential analyst.

At the outset, the patient, who in the meantime had gotten quite an education in psychology, hurled all sorts of intellectual challenges at his new therapist. With great vehemence, he accused modern psychology with its concept of "psychic realities" to reduce experience to a spectral world of unreal mirages. In reply, the therapist advised the analysand to set aside for a while his psychology. He suggested that the patient lie down on the couch, as he had done during his first analysis, and talk as freely as possible about anything that came to his mind, without sparing himself or the therapist. The patient was slightly startled by this challenge to do without psychology, but readily complied with the new proposal.

The first major difficulty of this third analysis appeared about six months after the beginning of therapy. The patient began to dream, almost nightly, of locked toilets; such dreams about inaccessible places always indicate that the person has to bring up something from the innermost depths of his being, but is not ready to do so. The patient was very annoyed at these toilet dreams which seemed to take him back to his first, Freudian analysis, which had at times been characterized by the same sort of nocturnal experience. The therapist restricted himself to drawing the patient's attention, in one or two sentences, to the resistiveness, the imperviousness, of his dream doors, thereby questioning the inaccessibility of the toilets hidden behind these doors. The therapist was prepared to precipitate a stormy resistance in this purebred aesthete by rattling at the locked toilet doors. Apparently, he had overestimated the psychic robustness of his patient whose relation to the obtruding fecal sphere and to the "lowly" realm of earthiness rapidly took on a severely psychotic form once he could no longer hide behind the compulsive polishing of "pure" crystal glass.



A dream was the prelude to the psychotic break. Once again, the patient found himself standing outside the locked door of a toilet. But this time his urge to defecate was so overpowering that he flung himself against the door with all his might and burst it open. But instead of getting through to the toilet, as he had expected, he discovered that he was standing in the middle of a large church, directly in front of the baptismal font. A thick rope hung from the vault over the ceiling of the tower. It was the rope with which the sexton tolled the largest bell in the tower. In his desperate urgency he had no choice but to hoist himself, on the bell rope, high up to the baptismal font where, still clutching the rope, he relieved himself. His defecating would not stop; soon he was standing knee-deep in his own stool. He tried to escape the rising mass of excrement by scrambling up the rope to the church tower, but his feet were stuck fast in the feces. Somehow, with all his frantic scrambling, the bell rope had twisted itself inextricably around his neck; his frenzied climbing exercises had set the bell in the tower in motion; and, most horrendous of all, with each resounding stroke, the rope, in some inexplicable fashion, wound itself around the axis of the bell. Between the upward tug of the rope and the downward pull of the cloying mass of feces, the dreamer was literally torn apart. At the height of his agony and terror, he woke up.

From this moment on the patient was frankly psychotic. He heard "voices" which called him obscene names. He was tortured by olfactory hallucinations. Wherever he went, he was pursued by an evil stench of sewage and excrement. He could hardly be induced to eat. In the days that followed he raged against the analyst for having let him feel the full filth of his creatural parts, thus robbing him of his human dignity. In his fury he smashed two large flower vases in the consulting room, hurling one at the wall close to the analyst's head. Then he ran home weeping, crept into bed, and lapsed into a catatonic state which lasted two days.

The analyst did not forsake his patient. He stayed with him all day and most of the night; he tube-fed him; and he insisted on taking care of the patient and his bodily needs with his own hands, like a good nurse. Forty-eight hours later, as he woke from his stupor, the patient flung his arms round the doctor tempestuously, like a very small child hugging its mother, and called out a hundred times over, "Mummy, Mummy, dear, dear." Then he opened his eyes wide, as if coming out of a profound sleep.

After this psychotic interlude, the patient made rapid progress. Boss used the psychotic crisis and the dream that had ushered it in, in order to point out to the patient that he had never granted either the earthy-excremental phenomena nor the heavenly-holy ones an entry into his world. He had never accepted either in its own right, and hence had been torn apart between them, as in his dream. Boss feels that the decisive difference between his own approach and that of the two other therapists lay in the fact that he encouraged the patient to confront the phenomena of his waking life and his dreams "as the immediate realities as which they presented themselves to him." He did not attempt to reduce church



towers to phallic symbols, as the Freudian analyst had done, nor to hypothetical archetypes, as the Jungian was wont to do. After all, Boss argued, during his psychotic state the patient had not doubted for one moment the immediate reality of what he was then experiencing.

Boss holds that the intense guilt feelings of this patient, as well as his whole symptomatology, were due, ultimately, to the patient's evasion of his full earthy-bodily as well as religious possibilities of behavior. He "had not fled merely from the encounter with a psychological symbol of libidinous or archetypal nature [as the Freudian or the Jungian would have it]. He had closed himself to the very disclosure of the earthy and the divine itself in their whole immediacy" (Boss, 1963, pp. 273 ff.).

It is clear that the existential analytic notions about the process and the goal of psychotherapy owe much to Jungian psychology. Other features of existential analysis are foreshadowed in the writings of such analysts and neoanalysts as Ferenczi, Reich, Rank, Horney, Fromm, Braatøy, and Sullivan, as well as in the work of non-Freudian psychologists, most notably Kurt Goldstein, Carl Rogers, and the Gestaltists. Thus there is hardly a single feature which existential analysis as a method of treatment can call indisputably its own; its more distinguished proponents, though, have assembled and elevated what in the work of others were disparate features without sufficient theoretical foundations to the dignity of a new systematic approach which, in spite of serious gaps and ambiguities, speaks with a distinctly original voice.

One of the major shortcomings of existential analysis is its tendency to volatilize empirical psychology in a contourless mist of metaphysical speculation. From an empirical point of view, it may well—but need not—be a dead end. If one would want to delineate personality profiles of psychological systems, one could say that psychoanalysis with its strong bent toward rational control is an obsessional system (in this it undoubtedly reflects the personality of its founder), and that existential analysis with its craving for immediate experience shows pronounced features of the hysteric. One of the dangers besetting the hysteric is his fondness of drowning himself in a stream of impressionistic experiences without firm intellectual coherence. Existential analysis has yet to prove its ability to escape this fate.

More radically than psychoanalysis ever did, existential analysis transcends the limits of a strictly medical endeavor. Not content to be a technique of healing, it offers itself as a method of salvation; to be more precise, it obliterates the distinction between medical and spiritual concerns. In the view of its more radical practitioners, no

cure is complete which cannot be described in terms of redemption. Laying claim to the total personality, and confronting man's spirituality on its own terms—without reducing it to a product of sublimation—existential analysis is bound to come to grips with questions of ultimate concern. It assimilates spiritual malaise, world alienation, and feelings of emptiness to neurotic symptoms, and in this it is at one with contemporary Western man who more and more often chooses to go to a psychotherapist when he gets weary of the lack of meaning in his life. Modern psychotherapy could have refused to heed this appeal, claiming lack of competence. But existential analysis, which has never sinned by excess of caution, is ready to respond to this demand, not in terms of a universally valid content (a new gospel), but in terms of a formal method of opening man up to immediate experience.

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